ART OF DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

**Consent for treatment of a minor child at Art of Dermatology PLLC**

I, being the parent / legal guardian of

_____

do hereby request and authorize the physicians/staff of Art of Dermatology PLLC to perform necessary services for my child, which are deemed advisable by the physician; whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

| Name | Relationship |
|---|---|
| | |
| | |
| | |
| | |

*This form should be witnessed by a member of the Art of Dermatology staff. If you are unable to accompany your child to his/her initial appointment, your signature must be notarized.

_____

Signature of parent or legal guardian

_____

Date

_____

Signature of witness

_____

Date