VENICE AVENUE DERMATOLOGY

CONSENT TO TREAT A MINOR

PATIENT NAME: _____ DOB: _____

I _____GIVE MY CONSENT FOR THE PROVIDERS AT
PARENT/GUARDIAN NAME

VENICE AVENUE DERMATOLOGY TO TREAT _____ IN MY ABSENCE.
NAME OF MINOR

I UNDERSTAND THAT THIS CONSENT TAKES EFFECT TODAY, AND WILL CONTINUE **UNLESS I SPECIFY AN END DATE BELOW**:

_____

THIS CONSENT IS FOR EVALUATION AND MEDICAL TREATMENT, INCLUDING ADMINISTRATION OF LOCAL ANESTHETIC, IF DETERMINED BY A PHYSICIAN TO BE NECESSARY**, UNLESS OTHERWISE STATED BELOW**:

_____

PLEASE CHECK APPLICABLE BOX:

☐ THE MINOR ABOVE MAY BE SEEN AND TREATED IN THE OFFICE WITHOUT A PARENT OR GUARDIAN PRESENT.

☐ THE MINOR ABOVE MAY BE SEEN AND TREATED IN THE OFFICE WHEN ACCOMPANIED BY:

NAME: _____ RELATIONSHIP TO MINOR: _____

PARENT/GUARDIAN NAME: _____

SIGNATURE: _____ DATE: _____