Dermatology Professionals · Inc

MEDICAL PERMISSION TO TREAT A MINOR CHILD

Patient Name: _____

_____

_____

(Full name of child, Address, Date of Birth)

As the parents/legal guardians of the above-named child, I/we give permission to authorize medical treatment to checked family member below:

Name: _____

( ) Grandparent ( ) Step-Parent ( ) Other Family Member

List any known allergies: (Food, medication, etc)

_____

_____

Parent/Legal Guardian Information:

Name, Address, Phone

_____

_____

_____

_____

Signature of Parent/Legal Guardian

_____

Date