CONSENT TO TREAT A MINOR

I am aware that my child may require treatment when I am not able to be present. In my absence, I give permission to _____ to authorize
(individual name/relationship to pt)

medical treatment for _____.
(name of minor/patient)

OR

In my absence, I give permission to **Ferrara Dermatology Clinic** to examine and provide treatment to my child, _____.
(patient name)

In addition, the clinic has my permission to refer my child's care to another appropriate physician to provide optimal care for the treatment of the illness or injury.

This agreement begins on _____ and ends on _____.

_____ _____ _____
Parent/Legal Guardian Signature **Relationship to Patient** **Date**

_____
Print Parent/Legal Guardian Name

_____ _____
Witness to Signature **Date**