El Segundo
Dermatology

CONSENT TO TREAT A MINOR

Patient's name: ____________________ DOB: ____________

I, ______________________________ , give my consent to the providers at El Segundo Dermatology
Parent/guardian name

to treat ______________________________ in my absence. I understand that
Patient's name

this consent takes effect today and will continue until ______________________________ .
Please specify date or write "indefinitely"

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:

____

CHECK APPLICABLE BOX

- ❐ The minor above may be seen and treated in the office without parent or guardian present.
- ❐ The minor above may be seen and treated in the office when accompanied by:

Name: ______________________________

Relationship to minor: ______________________________

Signature: ______________________________ Date: ____________