DIVINE
Dermatology

Consent to Treat a Minor

Patient's Full Name: _____

Patient's Date of Birth: _____

Important Note:

All minors must be accompanied by a parent or legal guardian on their first visit. After the first visit, this waiver can be signed to allow us to continue active treatment for the minor without the parent/legal guardian present at future visits.

I, _____, give the providers of Divine Dermatology
(Parent/Legal Guardian Name)

permission to treat my minor child _____ in my absence. **(Patient's Name)**

This includes permission to perform medically necessary procedures such as the prescribing of non-controlled medications. I understand that this form does not provide consent for medical procedures such as biopsy.

My signature below indicates my understanding of this form and approval. This consent will remain in force for up to twelve (12) months.

_____ _____
Printed Name of Parent / Legal Guardian **Date**

_____
Signature of Parent / Legal Guardian