Arsenault DERMATOLOGY

Skin Care For Your Family

Consent to Treat a Minor

Patient's Full Name: _____

Patient's Date of Birth:_____

I, _____, give the providers at Arsenault Dermatology
(Parent/Legal Guardian Name)
permission to treat my ***son / daughter / other*** _____ in my
(Patient's Name)
absence. 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

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