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 permission to treat
(Parent/Legal Guardian Name)

my **son / daughter / other** _____ in my absence. This includes permission
(Patient's Name)

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

MAIN OFFICE
8926 77th Terrace East
Suite 101
Lakewood Ranch, FL 34202
tel 941.907.0222
fax 941.907.0493

OFFICES IN
BRADENTON
LAKEWOOD RANCH
SARASOTA

ArsenaultDermatology.com