Advance Consent to Treat Minor Children

I, _____ (name of responsible party), hereby authorize all necessary dermatological treatment, deemed necessary by the dermatologist, for:

Name of Patient: _____

Date of Birth: _____

Miller Family Dermatology may provide treatment if my child is unaccompanied to his or her appointment, or if my child is accompanied by someone other than myself.

I have read a copy of Miller Family Dermatology's Important Information to Parents and Guardians of Minor Children.

Signature of Responsible Party (Guarantor): _____

Name (Print): _____**Date:**_____

Relationship to Patient: _____ **Witness Signature:** _____

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