CLEAR DERMATOLOGY

Consent To Treat A Minor

Patient's Name: ____ DOB: ___________________________

I, ____, give my consent to the providers at Clear Dermatology to
Parent/Guardian Name
treat ____ in my absence. I understand that this consent takes effect
Patient's Name
today and will continue indefinitely unless I specify an end date below:
____.

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: ___________________________