SKIN SPECIALISTS

OF THE CAPITAL REGION

SKINSPECIALISTSCR.COM

Permission to Treat an Unaccompanied Minor

Minor's Name:____ Date of Birth: _____________

I give my permission to have my minor treated in my absence by a provider at Skin Specialists of the Capital Region, PLLC

______ No adult needs to accompany my minor.

______ The person listed below will accompany my minor.

____

Parents Name:____

Signature of minor's parent:_____________________________________ Date:_______________

This consent remains in effect until_____________________________
This consent remains in effect Indefinitely. ____________________