ACCT#_____

Parental/Legal Guardian Consent to Treat a Minor

1. Minor ages 16-18 years of age (driving themselves to appointment):

I, _____, authorize the health care providers (Physician, Physician Assistant, or Medical Assistant) at O'Fallon Dermatology Specialists to provide medical care and perform necessary

medical treatment(s) for_____.

2. Minor of any age being brought by someone other than parent/legal guardian

I, _____, authorize the health care providers (Physician, Physician Assistant, or Medical Assistant) at O'Fallon Dermatology Specialists to provide medical care and perform necessary

medical treatment(s) for_____.

I also give _____
(list name and relationship of person with your child)
permission to make medical decisions regarding my child's care at today's visit.

Parent or Legal Guardian Signature:

SIGNATURE: _____

RELATIONSHIP: _____

PHONE: _____

DATE: _____