Patient Name and DOB _____

Parental/Guardian Consent to Treat a Minor

1. Minor ages 16-17 years who are driving to appointment without parent

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_____ (patient name).

2. Minor being brought by someone other than parent/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_____ (patient name).

3. List name, relationship, and phone number for anyone who may bring patient to the office and make medical decisions for the patient

_____

_____

_____

3. Duration for this parent/guardian consent (please mark or explain)

- ☐ Today's visit only
- ☐ For duration of treatment of a condition (circle or fill in condition)
  Accutane - acne - warts – eczema – other _____
- ☐ 1 year from date signed below
- ☐ Until the patient turns 18 years of age and can consent for themselves
- ☐ Other (describe) _____

Parent/Guardian Information and Signature

SIGNATURE: _____

RELATIONSHIP: _____

PHONE: _____

DATE: _____

7136 S. Outer Road 364 • O'Fallon, Missouri 63368
Phone 636.561.3277 • Fax 636.561.5280