

Franklin Dermatology Group/Latour Skin Care Center

Consent -- Treatment of Minor

Patient Name: _____ Date of Birth: ____/____/____

Many times parents/guardians find themselves unable to accompany their child/teen/ young adult to appointments. This form has been prepared for your convenience should you at any time be unable to accompany your child/teen/young adult or someone else accompanies your minor child. We require your permission to treat your unaccompanied minor in our office.

Parent/Guardian Signature

Date

This authorization shall be in force and effective until the time which it is revoked by the parent/guardian or patient becomes 18 years of age. _____

Initials – Parent/Guardian

Providers of Franklin Dermatology Group/Latour Skin Care Center reserve the right to refuse treatment of the minor for any reason. _____

Initials – Parent/Guardian

Complete this Section or initial - _____ Does not apply to this patient

Treatment of Minor Unaccompanied by an Adult or Parent/Guardian

I hereby grant the Providers of Franklin Dermatology Group/Latour Skin Care Center permission to treat my child/teen/young adult when he/she arrives at the office unaccompanied.

Print Name of Parent/Guardian

Relationship to Child

Signature of Parent/Guardian

____/____/____
Date

Contact Number(s): _____

Complete this Section or initial - _____ Does not apply to this patient

Treatment of Minor Accompanied by an Adult Other than Parent/Guardian

I hereby grant the Providers of Franklin Dermatology Group/Latour Skin Care Center permission to treat my child/teen/young adult when he/she arrives at the office accompanied by another adult.

Print Name(s) of Authorized Adult who will be bringing my Minor child/teen/young adult

Print Name of Parent/Guardian

Relationship to Child

Signature of Parent/Guardian

____/____/____
Date

Contact Number(s): _____