FORT WAYNE DERMATOLOGY CONSULTANTS INC

Consent to have a non-parent accompany a minor

Patient Information:

Name _____ MR _____

Date of Birth _____ Age_____

Parent, Guardian, or Responsible Party:

Name_____ Relationship to Patient _____

Many times parents find themselves unable to accompany their minor child to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hear by grant Fort Wayne Dermatology Consultants, Inc. permission to provide treatment in the event I, the parent or guardian of the minor listed above cannot attend the appointment.

I authorize the following individual(s) to accompany the minor child listed above _____.

Relationship to the above named minor _____

Fort Wayne Dermatology staff will still notify me if invasive procedures involving local anesthesia, biopsy of the skin, or surgical procedures are required during the visit.

I wish my child's treatment to be restricted as follows:

_____

_____

_____

Signature _____ Date _____

Printed Name _____

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