



Consent to Treat a Minor
for the following condition(s): _____

It is the policy of Integrity Dermatology that all minors (under 19 years of age) seeking dermatologic treatment for the very first time or upon the onset of a new problem be accompanied by a parent or legal guardian.

After the initial appointment, a minor may be seen by Integrity Dermatology for the same diagnosis without a parent or guardian present, upon completion of a **Consent to Treat a Minor** form. **A NEW PROBLEM WILL REQUIRE THE PRESENCE OF A PARENT OR LEGAL GUARDIAN.** This form authorizes Integrity Dermatology to evaluate and treat your minor child with your consent.

I authorize and give consent to Integrity Dermatology for the evaluation and medical treatment of my minor child without the presence of a parent or legal guardian.

Patient Name: _____

Age: _____ DOB: _____ Allergies: _____

Print Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

Emergency Contact: _____ Relationship: _____

Phone Number(s): _____

Additional person to contact in the event the parent or legal guardian cannot be reached:

Name: _____ Relationship: _____

(NOT a Parent or Legal Guardian)

Phone Number(s): _____