DERMATOLOGY CONSULTANTS OF FRISCO
AND
PRECISION DERMATOLOGY
Three Convenient Locations, One Great Team

Evaluation and Treatment Consent for Minors

Date: _____/_____/_____

Name: _____

DOB: _____/_____/_____

I request that a provider be allowed to evaluate and treat the individual above without a guardian or parent present. I understand that without a guardian or parent present at the visit, I may be unaware of any update, changes or new concerns. Each visit/treatment/surgery can be associated with risks, benefits and alternatives and I understand I will be relying on my child to communicate any changes or updates to me at a later time.

By signing this document, I am also affirming I am the legal guardian or legal parent of the listed minor.

Name of Minor:_____

Name of Parent/Guardian:_____

Signature of Parent/Guardian:_____

Scan Drivers License

Here

Match Signatures

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F. 972.668.8444

1601 W. HEBRON PKWY, STE 220
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