Consent for Medical Treatment of a Minor

Many times Parents/Legal Guardians find themselves unable to accompany their child to an appointment. This form has been prepared for your convenience should you at some time find yourself unable to be with them for the visit.

This form authorizes El Centro Dermatology to evaluate and treat your minor child/charge without you (the parent/legal guardian) being present. This permission may include but is not limited to treatment of lesions requiring minor surgical procedures, biopsies, injections, cryotherapy with liquid nitrogen or other minor destructive techniques, the writing of all prescriptions, UVB treatments, XTRAC laser treatments, blue light photodynamic therapy, cosmetic laser treatments, microneedling, chemical peels, and esthetician services.

I hereby give consent to El Centro Dermatology for medical evaluation and treatment of my child/charge if a parent/legal guardian is not present.

Payment for copays or any services not covered by insurance is expected the day of the appointment and can be made by cash, check, or credit card when checking in or in advance over the phone. An insurance card must be presented when checking in to every appointment.

I have the legal right to consent for medical treatment for this patient. I hereby authorize El Centro Dermatology to provide medical treatment as indicated above to my child in my absence. This is written to facilitate treatment since I am not able to be present with my child during the consultation although this is preferred by the clinic and the provider. I understand that I will accept full responsibility for the counseling and enforcement of the treatment methods as explained to my child and I am aware that I can always contact the clinic or provider for further information regarding my child. I also accept full responsibility for the cost of the treatment and consultation. This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to El Centro Dermatology.

Patient's Name: _____

Patient's Date of Birth: _____

Name of Parent or Legal Guardian: _____

Relationship to Patient: _____

Signature of Parent/Legal Guardian: _____

Date:_____