
**CONSENT TO TREATMENT OF MINOR CHILD**

I, _____ , (parent or legal guardian ) hereby authorize:

Dr. _____ and whomever he or she may designate as assistants to administer dermatological care as deemed necessary for my child _____.

This authorization is effective for six months from _____ to _____.

Printed Name: _____

Phone Number: _____

Signature: _____

Date: _____