PREMIER DERMATOLOGY
& COSMETIC SURGERY
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Newark DE 19713

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118 Sandhill Drive, Ste 104
Middletown, DE 19709

Medical Treatment Authorization and Consent for Minors

Child/Minor's Name: ____ **DOB:** _________________

Parent/Legal Guardian Name: ____

I, ____, being the (Check one) ☐ parent

☐ legal guardian of ____ [child] authorize

____ [caregiver], to seek, obtain and

consent to: (check all that apply)

- ☐ Routine Dermatological care and treatment
- ☐ Skin Biopsy
- ☐ Injections
- ☐ Minor procedures
- ☐ Other: _______________________________

for ____ [child] as deemed necessary by a licensed medical or healthcare professional. The authorization is for the time period when my child is in the care of ____ [caregiver],

my child's: (check one) *****must be 18 years of age or older, please indicate relationship below*****

☐ Grandmother	☐ Nanny
☐ Grandfather	☐ Babysitter
☐ Aunt	☐ Family friend
☐ Uncle	☐ Sibling
☐ Other: ____________________	

This consent is effective today, _____________________________, 20________ until (check one)

☐______________________________, 20________ ☐ revoked by me.

Parent/Legal Guardian Signature: ____**Date:** _____________