QUALDERM PARTNERS™
A SKIN & AESTHETICS WELLNESS FAMILY

Treatment of Minors

Patient Name: _____

Thank you for entrusting the dermatology care of your child to our practice. From time to time there are situations in which a parent/guardian cannot attend the appointment with their child. **Please choose the most suitable option(s) below that meets your wishes for the care of your minor patient, in the event you are not present:**

☐ As the parent/guardian of the above stated patient, **I allow the minor (16+) to attend appointments without my physical presence**. I understand this authorization is valid unless otherwise revoked. I acknowledge that all surgical appointments would require the physical presence of a parent/guardian. The minor may consent to participation in the routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.). I understand there may be instances in which the provider chooses to schedule the necessary treatment at a future date if my physical presence is deemed to be necessary.

☐ As the parent/guardian of the above stated patient, my child may attend appointments without me (legal guardian), however they may not attend alone. **My child may attend the appointment with the below individuals and the adult may consent to treatment on my behalf**. This treatment includes routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.) and may also consent to surgical procedures within the office.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

☐ As the parent/guardian of the above stated patient, I **DO NOT give consent for the patient to attend appointments without a parent/guardian** present at the appointment.

☐ The minor may attend an appointment without a parent/guardian/other adult, but I request to provide **verbal authorization before the appointment**. The patient may consent to participation in the routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.) once my verbal consent is given. I understand there may be instances in which the provider chooses to schedule the necessary treatment at a future date if my physical presence is deemed to be necessary.

Please note that both parents are considered legal guardians and may seek treatment/authorize treatment for the minor. If you have a court order indicating that a parent may not make these decisions for the patient, it is important that we receive a copy of this documentation for the patient's record.

The above treatment plan will remain in effect unless otherwise revoked and/or until the child turns 18. I understand that the Guarantor is financially responsible for any treatment provided.

Signature_____ Relationship: _____

Today's Date: _____

Office Use Only:

Verbal Authorization obtained for DOS _____ Parent/Guardian Authorizing: _____

Employee Witness 1: _____ Employee Witness 2: _____