Rochester Dermatology Clinic

Medical Consent to Treat A Minor Child/ Student

I _____ authorize Rochester Dermatology Clinic to provide medical treatment to _____ DOB:__/__/____ including, but not limited to, diagnostic examination, including acne treatments, laboratory test, screening, verification of necessary medical treatment, including minor surgical procedures in my presence and/or absence. I grant Rochester Dermatology Clinic providers, and other healthcare staff permission to provide routine, emergency or urgent care and treatment, for my child should medical attention be necessary while my child is in the office. I further give further give Rochester Dermatology Clinic permission to contact my child's primary healthcare provider regarding past medical and medication history, if necessary.

I understand that, should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I understand that, once my child reaches the age of 18, my consent for treatment is no longer required.

By signing this, I acknowledge that I have read and that I understand this consent. Any questions must be addressed with the office before signing.

Signature _____ ___/___/_____
(Parent/Guardian) Date

Parent or Guardian Emergency Contact

Home Phone: _____ Cell: _____ Work: _____

This authorization is effective one year from onset.