CONEJO DERMATOLOGY MEDICAL GROUP

CONSENT TO TREAT MINOR CHILDREN

*Please print or type all information*

I, ____________________________________________, parent or legal guardian

of ____________________________________, born __________, do hereby consent to any medical care related to my child's dermatology condition(s) determined to be necessary for the welfare of my child while said child is under the care of Dr. __________________________________ as I am not reasonably available in person to give consent.

This authorization is effective from __________________ to _______________.

_________________________________________________________________

Signature of Parent or Legal Guardian

______________________________ ________________________________

Witness Signature Witness Name (Please print)

Helpful information:

Telephone : Father: _________________________

Mother:_________________________

Legal Guardian:_________________________

Child's allergies to drugs: ________________________________________________

Special Medications currently taking: _______________________________________

Child's Physician: _____________________________Phone:___________________