

PERMISSION TO TREAT - UNACCOMPANIED MINOR PATIENT

Patient Name: _____ **DOB** _____

Address: _____

Phone: _____

Parent/Guardian Name: _____

Address & Phone _____

My signature below is my permission for the physicians and/or staff of **Van Dam Dermatology and Laser Center & Versa Medi Spa** to

treat my minor child, _____, for the following problems
Patient Name

_____.

I understand that appropriate treatment may include any or all of the following: Examination, advice, prescribing of medication, laboratory workup and/or biopsy, destruction, or excision of lesion(s). I understand that a minor, new patient, must be accompanied by a parent or guardian at their first appointment.

This permission to treat is valid until it is revoked in writing.

Signature of Parent or Guardian

Date

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