CENTRAL TEXAS
DERMATOLOGY
MEDICAL | SURGICAL | COSMETIC

Consent to Treat Minor Child

Minor Child's Name: ____

Date of Birth: ____

Allergies: ____

Medical Conditions: ____

I, (print name) ____, as the parent or legal guardian of ____, will not be present with my minor child for future office visits for reasons of my own personal convenience. My minor child has my permission to come to the office of Central Texas Dermatology for further routine office visits and associated procedures for the treatment of ____. I can be reached at (telephone number) ______________________________________.

______________________________ ______________________________

Printed Name of Parent/Guardian **Signature of Parent/Guardian**

______________________________ ______________________________

Printed Name of Witness **Signature of Witness**

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Date