Dermatology Center of
Southern Indiana

TREATMENT TO MINORS

Patient:______________________________________ Date of Birth:___________________________

Many times parents find themselves unable to accompany their child to an appointment. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant to the Dermatology Center of Southern Indiana permission to treat my child when they arrive at the office without a parent/guardian present. I understand a prescription may be written and instructions given without an adult present and that the provider will deem the appropriate method for treatment of their skin condition. I understand these methods may have potential side effects though uncommon, including but not limited to these four:

- Scarring
- Infection
- Bleeding
- Allergic Reaction

In the event of an emergency, I can be reached at:

Phone: ________________________________ Home

________________________________ Work

________________________________ Cell

I understand that I am responsible for payment of my account at the time of services for deductibles and co-payments and I will send money with my child to cover these fees.

X____ ________________________________

Signature of Parent or Guardian Date