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Advance Consent to Treat Minors

This agreement is required if you wish your unaccompanied child to be seen. My child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied. In my absence, I _____ grant Samir Master, MD, Casey Carlos, MD, PhD, and Liz Schuringa, ARNP permission to treat my child, _____.

Dermatology Arts is authorized to:

· provide routine and emergency medical treatment and perform necessary procedures related to treatment.
· call in prescription(s) and provide samples when applicable and available

This authorization will be effective for one year from date of signature.

_____	_____	_____
Signature of parent/legal guardian	Printed Name	Date