CONSENT TO TREAT MINORS

I, _____, the parent or legal guardian of

_____, Date of Birth: _____/_____/_____,

Grant permission for my child to be treated at Dermatology Associates of Morris, P.A., Parsippany, New Jersey.

Treatment may include (please check):

[ ] General medical care

[ ] Minor surgery which may be accompanied by the administration of local anesthesia (Lidocaine).

Please list any allergies and/or medical conditions that we should be aware of:

Name of Person/s authorized to bring in minor:
_____

_____

_____

This authorization is effective (please check):

[ ] Today Only _____/_____/_____

[ ] From _____/_____/_____ to _____/_____/_____

At the time of the visit, the parent/guardian can be located at the following phone number:

Name: _____

Phone Number: _____

Signature of Parent or Legal Guardian: _____