

CONSENT FOR TREATMENT OF MINOR

Minor Patient Name:	Date of Birth:
• •	g people to make decisions regarding the treatment of aminations, injections and/or procedures. I understand to authorize treatment.
Name	Relationship to patient
	inless so designated in writing that such consent for tify Water's Edge Dermatology of any changes as to the
Name of Parent or Guardian	Relationship to patient
Signature of Parent or Guardian	Date