CONSENT FOR TREATMENT OF MINOR

Minor Patient Name: _____ Date of Birth: _____

I hereby give permission for the following legal adults to make decisions regarding the treatment of my child including, but not limited to, examinations, injections and/or procedures. I understand those listed below will have the authority to authorize treatment.

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient

This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I will notify Water's Edge Dermatology of any changes as to the health status of my child.

Name of Parent or Guardian	Relationship to patient
Signature of Parent or Guardian	Date

If approved by my child's practitioner, I authorize and give consent for my child (**age 16 or 17**), listed above, to go independently to appointments for the purpose of **monthly Accutane visit checks only**. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments.

Signature of Parent or Guardian	Date

_____
Witness Signature/Name

*In the event you are unable to complete in office or via secured portal you must have notarized to be valid.

State of Florida
County of _____

Sworn to (or affirmed) and subscribed before me this _____day of _____, _____, by_____.
(month) (year) (name of signer)

____ Personally Known
____ Produced Identification
Type and # of ID _____

_____
(Signature of Notary)

(Seal)

_____
(Name of Notary Typed, Stamped, or Printed)