BEACHES
DERMATOLOGY

www.beachesdermatology.com

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Parental Authorization to Treat a Minor

Minor Name: _____ **Date of Birth:** _____

Beaches Dermatology requires the parent/legal representative to be present for new patient visits for minors.

I am the parent/legal representative and have the legal authority to authorize the examination and treatment of my son/daughter by Beaches Dermatology health care providers.

I understand that the examination and treatment may include the use of microdermabrasion, IL or IM injection, liquid nitrogen, laboratory tests, medications (oral or topical) and other diagnostic procedures and tests normally provided in dermatological care.

I authorize the examination and treatment by Beaches Dermatology without my presence. I understand that this authorization applies and extends to subsequent visits and appointments at Beaches Dermatology, even if my child is not accompanied by me or any other adult, and is valid until my child is the age of 18 years or until otherwise advised by the parent/legal representative in writing.

I understand it is my obligation to know when my child is examined and treated at Beaches Dermatology, to know who accompanied my child to the visit, if anyone, and to take steps promptly following the visit to make sure I understand the recommendations and plans instituted by Beaches Dermatology to address my child's health needs. I understand the recommendations and plans instituted by Beaches Dermatology to address my child's health needs will be shared with the person who accompanied my child to the visit, and that it is my responsibility to obtain the recommendations and plans from Beaches Dermatology as necessary.

Print Name (Parent/Legal Guardian): _____ Relationship to Patient: _____

Signature (Patient/Legal Representative) _____ Date: _____