DERMATOLOGY ASSOCIATES
OF NORTHERN MICHIGAN, P.C.

PARENTAL CONSENT FOR TREATMENT OF A MINOR

I hereby authorize Dermatology Associates of Northern Michigan, P.C. providers to evaluate and treat my minor child in my absence.

- I understand that I, or an adult guardian, am expected to attend all of my child's appointment whenever possible
- I acknowledge that having my minor child evaluated and treated, without an adult present, is a courtesy extended by Dermatology Associates of Northern MI and as such can be revoked at any time for any reason.

I specifically allow Dermatology Associates of Northern Michigan, P.C. to evaluate and treat my minor child.

I acknowledge that certain medical conditions and/or therapies may pose significant risk to the health and well-being of my child.

- If my child has such a condition or requires treatments that pose significant risk of side effects, I or an adult guardian will be required to be present at all appointments.
- I understand that under these circumstances my minor child will **not be** evaluated or treated in the absence of a parent or guardian.

I am aware that my minor child may be sent home with information pertaining to the rendered diagnosis and selected treatment. This information may contain the risks that therapy may pose to my child.

- I understand that I may call the office to acquire additional information about the diagnosis and treatments.
- I acknowledge that if the frequency and duration of calls becomes disruptive to Dermatology Associates of Northern Michigan, P.C. staff, my minor will no longer be evaluated in the absence of a parent or guardian.

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Childs name **Birthdate**

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Parent or guardian **Date**

______________________________ ______________

Witness **Date**

4170 CEDAR BLUFF DR * PETOSKEY, MI 49770 * P231.487.2230 * F231.487.6172