LAKEWAY DERMATOLOGY

Skin Cancer, Cosmetic & Laser Center

Consent for Medical Treatment of a Minor (optional)

Patient Name: _____ Date of Birth ____/____/_____

Parent Name/Guardian: _____

A parent/legal guardian must accompany all minors seeking medical treatment during the first office visit for a new problem. After the initial appointment, a minor may be seen for treatment only with written authorization from the parent/guardian under the conditions specified in this consent. If the parent/legal guardian cannot attend the appointment, the following instructions that you select will be adhered to in the treatment of the minor patient. For all NEW problems, an established minor patient must have a parent or legal guardian present for discussion and treatment. For all surgeries, a minor patient must have a parent or legal guardian present. **For all Isotretinoin visits, a parent/guardian must be present at all visits.

FOR ESTABLISHED MINOR PATIENT- Follow-up of a previously diagnosed condition
REFILLS
_____Yes _____No I authorize Lakeway Dermatology to refill prescriptions for the minor as deemed necessary for treatment including dosing changes on current medications

NEW PRESCRIPTIONS
_____Yes _____No I authorize Lakeway Dermatology to write new prescriptions for the minor as deemed necessary for treatment.

*If you need to send your child to their appointment with an adult other than yourself/legal guardian, please complete this section:
I appoint the following adult _____, whose relationship to the child is _____ to consent to medical care which is deemed necessary by Lakeway Dermatology.

I certify I am the parent/legal guardian of the minor child. I have the legal right to consent for medical treatment for this patient. I hereby authorize Lakeway Dermatology to provide medical treatment as indicated above.

Parent/Legal Guardian Signature: _____ Date ____ /_____/_____