

## **CONSENT TO TREAT MINOR CHILD**

1,				, parent or lo	egal guardian
of		<del></del>		, date of birt	th,
		(name of child)			
	reby consent to any medical care by Melinda J. Woofter, M.D. to be				
	•	•		child is under the	
Integ	grated Dermate	ology Group/Mi	dwest Derma	tology Centre, L	LC.
□ N alon		ween the ages of	f 16-18 and w	ill be attending	appointment
$\square$ N	ly child will b	e accompanied,	with my pern	nission, by	•
This	authorization	is effective fron	n	to	·
Sign	ature of Paren	t or Legal Guard	dian		
Sign		C			
Sign	Your child n	eeds to bring th	is form with	him/her at time	<u>of</u>
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<sup>\*</sup> If this is the child's initial visit or surgical procedure, a parent must accompany.