CONSENT TO TREAT MINOR CHILD

I, ____, parent or legal guardian
of____, date of birth_________,
(name of child)
do hereby consent to any medical care by Melinda J. Woofter, M.D. to be necessary for the welfare of my child while said child is under the care of Integrated Dermatology Group/Midwest Dermatology Centre, LLC.

☐ My child is between the ages of 16-18 and will be attending appointment alone.
☐ My child will be accompanied, with my permission, by_______________.

This authorization is effective from________________to________________.

____
Signature of Parent or Legal Guardian

Your child needs to bring this form with him/her at time of appointment and present during check-in.

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family address____

Telephone: Father ___________home__________cell_________work

Mother___________home__________cell_________work

Allergies: ____

Medications: ____

*** If this is the child's initial visit or surgical procedure, a parent must accompany.**