Consent for Treatment of a Minor Child

I, as parent or guardian of Name/DOB: _____, do hereby request and authorize the physicians and staff of DermWellesley, LLC to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

_____

_____

_____

_____ **_____**

Signature of Parent or Guardian **Date**

_____

Printed Name of Parent or Guardian

_____ **_____**

Witness Signature **Date**

_____

Printed Name of Witness

<u>This form should be witnessed by a member of the DermWellesley team.</u> If you are unable to accompany your child to his or her initial appointment, your signature must be notarized.

20 William Street, Suite G15, Wellesley, MA 02481
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