Sunshine State DERMATOLOGY AND SKIN CANCER CENTER

CONSENT FOR TREATMENT OF UNACCOMPANIED MINOR

Important Note:

All minors must be accompanied by a parent or legal guardian on their first visit. After the first visit, this waiver can be signed to allow us to continue active treatment for the minor without the parent/legal guardian present at future visits.

I, _____, give the providers of Sunshine State Dermatology and Skin
(Parent/Legal Guardian Name)
Cancer Center Inc. permission to treat my minor child _____ in my absence.
(Minor Patient's Name and DOB)

This includes permission to perform medically necessary procedures including prescribing of non-controlled medications in my absence.

My signature below indicates my understanding of this form and approval. This consent will remain in force for up to twelve (12) months.

Please be sure to send the insurance card and co-pay (if applicable) to the appointment.

In case of Emergency, I can be reached at:

Home: _____ Work: _____Cell:_____

Please send current insurance information with your child or the party accompanying them.

Signature of Parent or Guardian :_____Date:_____