



Consent to Treat a Minor

I, _____, am the parent or legal guardian of _____,
born _____. I authorize and give consent to Colorado Dermatology Institute's
practitioners to medically evaluate and treat my child for the following conditions:

In the event I am unable to bring the above mentioned minor to their appointment, I authorize the
following adults to escort said minor to their appointment:

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship

I have read and completed the full Consent located in this Patient Registration package.

Signature of Parent/Legal Guardian

DOB of Parent/Legal Guardian

Relationship to Minor

Daytime Phone Number