Colorado Dermatology Institute

affiliated with

Department of Dermatology
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

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

_____
Date Signed

_____
DOB of Parent/Legal Guardian

_____
Relationship to Minor

_____
Daytime Phone Number

North Location: 8580 Scarborough Drive, Suite 225
Colorado Springs, CO 80920

South Location: 1220 Lake Plaza Drive
Colorado Springs, CO 80906

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