



YORBA LINDA
DERMATOLOGY
MEDICAL ♦ SURGICAL ♦ COSMETIC

Consent To Treat A Minor

Patient's Name: _____ DOB: _____

I, _____, give my consent to the providers at Yorba Linda Dermatology to
Parent/Guardian Name
treat _____ in my absence. I understand that this consent takes effect
Patient's Name

today and will continue indefinitely unless I specify an end date below:

_____.

This consent is for evaluation and medical treatment including administration of local anesthetic if determined by a physician to be necessary, unless otherwise stated below:

Check applicable box:

- The minor above may be seen and treated in the office without parent or guardian present.
- The minor above may be seen and treated in the office when accompanied by:

Name: _____

Relationship to minor: _____

Signature: _____ Date: _____