Dermatology of Southeastern Ohio
817 Forest Avenue
Zanesville, OH 43701

Treatment of Minors

Patient Name: _____ Patient DOB: _____

Thank you for entrusting the dermatology care of your child to our practice. From time to time there are situations in which a parent/guardian cannot attend the appointment with their child. Please choose the most suitable option(s) below that meets your wishes for the care of your minor patient, in the event you are not present:

❒ As the parent/guardian of the above stated patient, **I allow the minor (16+) to attend appointments without my physical presence**. I understand this authorization is valid unless otherwise revoked. I acknowledge that all surgical procedures would require the physical presence of a parent/guardian. The minor may consent to participation in the routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.). I understand there may be instances in which the provider chooses to schedule the necessary treatment at a future date if my physical presence is deemed to be necessary.

❒ As the parent/guardian of the above stated patient, my child may attend appointments without me (legal guardian), however they may not attend alone. **My child may attend the appointment with the below individuals and the adult may consent to treatment on my behalf**. This treatment includes routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.) and may also consent to surgical procedures within the office.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

❒ As the parent/guardian of the above stated patient, I **DO NOT give consent for the patient to attend appointments without a parent/guardian** present at the appointment.

❒ The minor may attend an appointment without a parent/guardian/other adult, but I request to provide **verbal authorization before the appointment**. The patient may consent to participation in the routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.) once my verbal consent is given. I understand there may be instances in which the provider chooses to schedule the necessary treatment at a future date if my physical presence is deemed to be necessary.

Please note that both parents are considered legal guardians and may seek treatment/authorize treatment for the minor. If you have a court order indicating that a parent may not make these decisions for the patient, it is important that we receive a copy of this documentation for the patient's record.

The above treatment plan will remain in effect unless otherwise revoked and/or until the child turns 18. I understand that the Guarantor is financially responsible for any treatment provided.

Signature_____ Relationship: _____

Office Use Only:

Verbal Authorization obtained for DOS _____ Parent/Guardian Authorizing: _____