Charleston Dermatology
PLLC

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# Consent for Treatment of a Minor Child

I, as parent or guardian of Name/DOB: _____, do hereby request and authorize the providers and staff of Charleston Dermatology, PLLC to perform necessary services for my child that are deemed advisable by the physician or nurse practitioner, whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

_____

_____

_____

_____ _____

Signature of Parent or Guardian Date

_____

Printed Name of Parent or Guardian