ASPEN
DERMATOLOGY

Consent for Treatment of a Minor Without Legal Guardian Present

I, ____ give permission for my child,

____________________________________birthdate________________ to

obtain medical treatment from Aspen Dermatology when I cannot be reached or

when a delay in care would be dangerous for my child.

This consent will remain in effect:

- € only for the date listed _________________________
- € until the patient is 18 years old

Parent/Guardian Name ____

Address____

Home Phone ______________________ Cell Phone ______________________

E-mail address ____

I understand that I assume all financial responsibility for any treatment provided

by Aspen Dermatology.

___________________________________ ________________________

Signature of Parent/Guardian Date