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