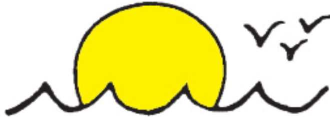

Atlantic Dermatology Associates, P.C.

Dermatology and Dermatologic Surgery

Treatment of a Minor

Patient Name: ________________________________ **Date of Birth:** ____/____/____

If I am unable to accompany my child to their physician appointment at Atlantic Dermatology Associates, I give my permission to the listed names below to accompany the patient in my absence. ***Please note names listed below will be allowed to accompany, and make decisions on my behalf.***

Name	**Relationship**
______________________________________	______________________
______________________________________	______________________
______________________________________	______________________
______________________________________	______________________

____ ____/____/____

Signature of Parent/Guardian **Today's Date**