Bluegrass Dermatology
Skin Surgery Center, P.S.C.

Authorization for Treatment of a Child

Name of Child: _____ Child's Birth Date: _____

Name of Parent/Legal Guardian: _____

Parent/Legal Guardian Phone Number: _____

□ By checking this box, I, the undersigned parent or legal guardian, authorize Bluegrass Dermatology to evaluate and provide treatment to my minor child in my absence or in the absence of the adult(s) listed below.

I, the undersigned parent/legal guardian, authorize the following adult(s) to accompany my child to Bluegrass Dermatology and, on my behalf, to:

- Provide consent to routine medical evaluation and treatment.
- Provide relevant medical history and information necessary for the child's care.
- Consent to routine dermatologic procedures recommended ty the treating provider.
- Consent to medications and treatment recommendations.
- Receive instructions regarding the child's treatment and follow-up care.

_____ _____
(Print Authorized Adult's Full Name) (Print Relationship to child)

_____ _____
(Print Authorized Adult's Full Name) (Print Relationship to child)

I understand that the healthcare provider may determine that additional consent from the parent/legal guardian is necessary before performing certain procedures or providing certain treatments.

PARENT/LEGAL GUARDIAN CERTIFICATION

I certify that I am the parent or legal guardian of the minor named above and that I have the legal authority to authorize medical care for this child.

I understand that I am giving the above-named adult(s) permission to accompany my child and consent to treatment within the scope of this authorization.

I may revoke this authorization by notifying the practice in writing, subject to any treatment or actions already taken based upon this authorization.

_____ _____
(Signature of Parent/legal guardian) (Date)