

CONSENT TO TREAT A MINOR

Patient Name: _____

Date of Birth: _____

Parent/Legal Guardian Name: _____

Relationship to Patient: _____

Purpose

This form authorizes the dermatology providers and staff at EVI Dermatology to evaluate and provide medical treatment to the minor named above.

Consent for Evaluation and Treatment

I, the undersigned parent or legal guardian, hereby authorize the licensed medical providers of **EVI Dermatology** to provide medical services to my child, including but not limited to:

- Medical history review and physical examination
- Diagnostic testing (e.g., laboratory, biopsy, or imaging)
- Administration of medications, injections, or local anesthesia as indicated
- Treatment of dermatologic conditions, including minor procedures
- Follow-up care as deemed necessary by the provider

I understand that I will be informed of any significant findings, diagnoses, or recommended treatments. I acknowledge that no guarantee can be made as to the results of any examination or treatment.

Consent for Treatment in Absence of Parent/Guardian (Optional)

I authorize my child to receive medical care in my absence.

I authorize the following individuals to consent to treatment on my behalf if I am not available:

1. _____ Relationship: _____

2. _____ Relationship: _____

Financial Responsibility

I understand that I am financially responsible for all charges incurred for my child's medical care, whether or not covered by insurance.

Acknowledgment and Signature

I have read and understand the information above. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.

Parent/Guardian Name: _____ **Date:** _____

Parent/Guardian Signature: _____