

BAY AREA DERMATOLOGY
Consent for Treatment of Unaccompanied Minors

This will verify that we/I hereby authorize any and all doctors from Bay Area Dermatology or those designated by them to evaluate, diagnose, and treat my child(ren) brought by a person other than ourselves or when reporting unaccompanied, to the Bay Area Dermatology office.

My child(ren) whose name(s) and date(s) of birth follow:

Names	Dates of Birth
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

This permission is valid until revoked by notice to Bay Area Dermatology in writing.

Signed: _____

Date: _____