THE DERMATOLOGY CENTER OF INDIANA

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I (we) the undersigned parent, parents, or legal guardian of _____, A minor, do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of_____, a duly licensed physician, licensed under the provisions of the laws in the state of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of this best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions:_____

Signature of Parent or Legal Guardian:_____
Date: _____

This consent shall remain effective until the minor can legally consent for themselves, is discharged from the above practice or is revoked in writing by the minors' Parent or Legal Guardian.

The following people may present the minor child for treatment:

Name	Relationship to Minor
_____	_____
_____	_____

Medical Information

Birth date:_____ Allergies:_____

Any special medications or pertinent information:_____

Telephone number where parents or legal guardian can be reached:

Name:_____Home:_____Cell:_____
Name:_____Home:_____Cell:_____