THE DERMATOLOGY CENTER OF INDIANA

Minor Consent

This form must be completed in order for The Dermatology of Indiana to provide care for anyone under 18 years of age who is accompanied by a supervising adult other than the legal guardian.

CHILD'S NAME:

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: _____ Allergies: _____

PRIMARY CARE PROVIDER INFORMATION

Doctor's Name:_____

Office Address: _____

Office Phone Number: _____ Office Fax Number: _____

Medical Insurer/Health Plan: _____ Policy #: _____

PARENT/LEGAL GUARDIAN #1

Last Name: _____ First Name: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email:_____

Additional Contact Information: _____

PARENT/LEGAL GUARDIAN #2 (if applicable)

Last Name: _____ First Name: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email: _____

Additional Contact Information: _____

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I do hereby swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for the supervising adult(s) named below to seek medical attention for my child, including contacting medical personnel, transporting the child to the necessary clinic or hospital, and providing consent for any medical procedure, transfusion, medication, treatment or care diagnosed and administered by any licensed medical personnel.

SUPERVISING ADULT #1:

Last Name: _____ First Name: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email:_____

Additional Contact Information: _____

SUPERVISING ADULT #2:

Last Name: _____ First Name: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email:_____

Additional Contact Information: _____

SUPERVISING ADULT #3:

Last Name: _____ First Name: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email:_____

Additional Contact Information: _____

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This authorization is given, prior to any immediate or pressing medical need, in order to provide the power of decision and the authority to act on the prudence and judgment of the Supervising Adult, with the provided input of authorized medical personnel.

This annual medical consent is authorized to begin on the date indicated below and will remain in effect for the duration of the calendar year, unless otherwise indicated by a parent or legal guardian. A new form will need to be signed on January 1 of each successive calendar year.

_____ _____

Parent/Legal Guardian #1's Signature Date

_____ _____

Parent/Legal Guardian #2's Signature (if applicable) Date