PLATINUM DERMATOLOGY NETWORK™

Evaluation & Treatment Consent for Minors

Date: _____/_____/_____

Patient Name: _____ **DOB:** _____/_____/_____

Guardian Email: _____

I request that a provider be allowed to evaluate and treat the individual above without a guardian or parent present. I understand that without a guardian or parent present at the visit, I may be unaware of any update, changes or new concerns.

Each visit/treatment/surgery can be associated with risks, benefits and alternatives and I understand I will be relying on my child to communicate any changes or updates to me at a later time.

By signing this document, I am also affirming I am the legal guardian or legal parent of the listed minor.

Name of Minor: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Scan Drivers License

Here

Match Signatures