ADVANCED DERMATOLOGY and COSMETIC SURGERY
PARENTAL
TEMPORARY ASSIGNMENT of AUTHORIZATION to TREAT MINOR CHILD

MINOR`S FULL NAME_____DOB_____

I am aware that my child may require treatment when I am not able to be present. In my absence, I give to _____
[Individual name and relationship to patient]
my permission to authorize non-invasive medical treatment for my child.

This agreement begins_____and ends_____

_____ _____ _____
Parent/Legal Representative Signature Relationship to patient Date/Time

Print Parent/Legal Representative Name

_____ _____
Witness to Signature Date and Time

MEDICAL, PHYSICAL AND INSURANCE INFORMATION

Please complete:

Weight_____Height_____

Allergies_____

Medications:_____

Previous Surgeries:_____

Chronic Illnesses:_____

Other pertinent medical information_____

Insurance Carrier:_____Policy#_____ID#_____