

## Parental Consent for Treatment of Minor

I, \_\_\_\_\_ the parent/guardian of \_\_\_\_\_

hereby authorize and consent to medical care for my child in my absence.

This authorization shall be valid from \_\_\_\_\_ to \_\_\_\_\_.

I do hereby indemnify and hold harmless Chelsea Skin & Laser, its caregivers, staff, or any person involved in providing care to my child who act in reliance upon this authorization.

**A child's parent or legal guardian must be contacted to discuss any treatments, medications, procedures or changes in treatment plan. The administering of any procedures can only be done in the presence of a parent/legal guardian or after the procedure has been discussed with the parent/legal guardian and the proper consent form(s) have been signed.**

Please understand that this form is NOT intended to replace any other forms that the practice may require prior to treating your child. (Example: Medical History, HIPAA, surgical/treatment consents). All other documentation will need to be updated/signed prior to any treatment being initiated.

In the event of a life-threatening emergency, the child may be treated without parental consent. We will do our best to contact the parents or legal guardian.

My child will be accompanied by \_\_\_\_\_

Relationship \_\_\_\_\_

Parent/Legal Guardian Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_

The practitioner may want to discuss the visit with you.

Please provide a phone number where parent/guardian can be reached at the time of the appointment:

\_\_\_\_\_

**AREAS in RED REQUIRED**