Dermatology Associates
of Western Connecticut, PC

Parental Consent for Medical Evaluation and Treatment of a Minor Child

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This authorization is valid from : _____ to _____
date date

Child's Full Name: _____ D.O.B.: _____

Parent/Guardian Name: _____

Parent/Guardian BEST Contact Number: _____

I understand my child is under 18 and do hereby consent to the medical evaluation and treatment of my child by Dermatology Associates of Western Connecticut as deemed necessary by a clinician and in the absence of a parent and/or guardian.

I understand that I will be contacted further if additional permission for cosmetic or medical procedures is required.

For future visits I give permission for _____ to bring my child to the doctor in my place for one calendar year from date of signature.

- Name & Relationship _____
- Name & Relationship _____

_____

Parent/Guardian Signature Today's Date

Main Office:
170 Mount Pleasant Road, Suite 201
Newtown, CT 06470

203-792-4151
Fax: 203-792-4155
Email: office@dermwestconn.com