MODERN DERMATOLOGY
OF MASSACHUSETTS

Modern Dermatology of Massachusetts

10 North Main Street, Suite 402

Fall River, MA

CONSENT TO TREAT A MINOR

Patient Name: _____

Date of Birth:_____

Home Address: _____

Date of Appointment:_____

PARENT/GUARDIAN COMPLETE THE FOLLOWING: I, the undersigned parent/legal guardian, of the minor named above, authorize the clinician at Modern Dermatology of Massachusetts, to provide healthcare services to this minor named above in the absence of a parent or legal guardian. I understand that the healthcare services may include, but are not limited to: examination, medical or surgical diagnosis, local anesthetic, and preventative and/or curative treatment.

State any restrictions or exceptions: _____

Parent/Guardian Name (please print or type): _____

Parent/Guardian Signature: _____

Telephone number where you can be reached at the time of appointment

Home/Cell/Work: _____

Please fax the completed form to: (434) 423-4783, mail to the address above, or have the patient bring the form to their appointment.