Central Florida
DERMATOLOGY
ASSOCIATES

Minor Consent Form

I, *(please print)* _____, parent/legal guardian of

(please print) _____, give my consent to the staff of Central Florida Dermatology Associates to evaluate and/or treat my child without my presence.

Please circle one:

A- Unaccompanied by an adult (child must be 17 years of age)

B- Accompanied by another adult who is at least 18 years of age:

Name of accompanying adult: *(please print)* _____.

I understand it is my responsibility to provide a copy of my valid photo I.D. on the date of service in order for my child to be treated. Please note: The providers have the right to refuse treatment at any time, should it be a case in which the presence of a parent/legal guardian is required. Minors 16 years of age or younger must be accompanied by an adult.

Signature Date