Central Florida DERMATOLOGY ASSOCIATES

Kathleen W. Judge, M.D.
Medical Director
Diplomate American Board of Dermatology
Dermatology and Dermatologic Surgery

I, _____, parent/legal guardian of _____, give my consent to the staff of Central Florida Dermatology Associates to see my child with _____ without my presence on _____ and for the remainder of the year. I also 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 the parent/ legal guardian is required for treatment.

_____

Signature Date