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 without my

presence on ______________________ and for the remainder of

the year. I also agree 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 that although my consent has been given, I understand

the provider reserves the right to refuse treatment at any time,

should she determine the presence of the parent/legal guardian is

necessary.

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Signature Date