Minor Consent Form

I, ___________________________________(parent or legal guardian), understand that Owensboro Dermatology Associates, PSC has advised me that it is in my child's best interest that he/she be accompanied by either a parent or legal guardian when being treated.

Therefore, I hereby authorize the physicians and staff of Owensboro Dermatology Associates, PSC to treat my child, ____________________________(patient name), when not accompanied by a parent or legal guardian. Since my child will not be accompanied by an adult, I authorize the physicians and staff of Owensboro Dermatology Associates, PSC to administer any medical treatment necessary in an emergency situation.

I hereby release the physicians and staff of Owensboro Dermatology Associates, PSC from all liability related to the emergency care and treatment of my aforementioned child.

Patient: ________________________________ DOB: ________________________

Signed: ________________________________ DATE: ________________________
Parent or Guardian