



THE WOODLANDS
DERMATOLOGY
ASSOCIATES

TREATMENT TO MINORS

Patient Name: _____ DOB: _____

Many times, parents/guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Dr. _____ permission to treat my child specifically for _____ when they arrive at the office unaccompanied.

Signature of Parent

____/____/____
Date
