Gardens Dermatology
11030 RCA Center Drive
Palm Beach Gardens, FL 33410
561-776-7041 (phone)
561-776-7043 (fax)

TREATMENT TO MINORS

Many times, parents find themselves unable to accompany their teen or young children to appointments. This form has been prepared for your convenience when you find yourself unable to accompany your child.

I hereby grant Dr. ______________________ permission to treat my child when they arrive unaccompanied to the office.

My minor child will be coming to the office for regular treatment of his or her dermatological condition unaccompanied. I authorize the above Dr. to examine my child.

If my child should require treatment of his or her condition I authorize the above Dr. to perform a biopsy or write prescriptions for their condition.

I also understand that my child may have a copayment due at the time of their visit. I agree to send my child to the office prepared for payment, if applicable.

Name of child: ____ Copay: _________

Condition child will be seen for: ____

Parent signature: ______________________________________ Date: __________