VUJEVICH
DERMATOLOGY ASSOCIATES, PC

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PEDIATRIC TREATMENT CONSENT

CONSENT TO TREAT A MINOR

I, _____, the parent/legal guardian of _____,

born on _____, hereby consent to all medical care, procedures, and the prescribing or changing of medications determined necessary for treatment by a provider within Vujevich Dermatology Associates while in the presence of an adult listed below if I am unable to personally attend the office visit.

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

Signature of parent/legal guardian Today's Date

CONSENT FOR MINOR TO ATTEND APPOINTMENTS WITHOUT A LEGAL GUARDIAN

I, _____, the parent/legal guardian of _____,

born on _____, hereby consent to all medical care, procedures, and the prescribing or changing of medications determined necessary for treatment by a provider within Vujevich Dermatology Associates without a parent or guardian present. I understand I will not be contacted to review the office visit, but I may call into the office with any questions for the medical staff regarding the treatment plan for the above-mentioned minor.

Signature of parent/legal guardian Today's Date