M | D

MODERN DERMATOLOGY

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CONSENT TO TREAT MINOR CHILDREN

(when seen under someone else's supervision – non parental)

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care determined by Rhonda Klein, MD, MPH, FAAD and Deanne Mraz Robinson, MD, FAAD or other medical provider within Modern Dermatology of Connecticut to be necessary for the welfare of my child while said child is under the care of_____, and I am not reasonably available by telephone to give consent.

This authorization is effective from _____ to _____

Signature of Parent or Legal Guardian _____

Witness Signature Witness Name (please print) _____

This additional information will assist in treatment if it can be furnished with the consent, but it is not required.

Contact:
Mother's name: _____ Phone number: _____

Father's name: _____ Phone number: _____

Allergies to drugs or food _____
_____

Medications or Pertinent Information _____
_____

Primary Care Physician _____