Dermatology Associates of Kentucky, PSC

Consent to Treat Minor

I, ___________________________, the parent/legal guardian of the below named minor,
Print Name

______________________________ ________________________
Minor's First & Last Name *Minor's Birthdate*

hereby authorize and consent to the examination and/or treatment of my minor child during office visits by the physicians and clinical staff of Dermatology Associates of Kentucky PSC. In addition, I give permission for the following person(s) to bring my minor child to DAK in my absence and act on my behalf in authorizing medical care and treatment in my absence. In the event of an emergency or other illness, I understand that the physicians and staff of DAK will deliver any medical care deemed necessary regardless of the accompanying adult.

(Until we are notified in writing, Dermatology Associates of Kentucky, PSC will assume that a child's biological &/or legal parents are both legal guardians who have access to treatment options and medical information for that child.)

Name ____

Relationship ____________________________________

Name ____

Relationship ____________________________________

Name ____

Relationship ____________________________________

***Anyone not mentioned above who brings your child in to the office for treatment must have a notarized signed authorization from the child's legal guardian.*

I acknowledge I have received Dermatology Associates of Kentucky, PSC Consent to Treatment Information.

______________________________ ________________________
Parent's Signature *Date*

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