COMPLETE DERMATOLOGY

Date: _____

I, _____ allow Complete Dermatology to see my
(parent/guardian name)

daughter/son _____ during any future follow up
(full name of minor)

appointments without my presence. I understand that Complete Dermatology will not be

performing any treatments without my explicit consent.

Please Select One:

_____ ☐ I designate _____ to bring my child to his/her
(initial) (Authorized Adult)

visit on the appointment date of _____.
(Date)

_____ ☐ I allow my daughter/son to be seen without an adult present.
(initial)

I allow my daughter/son to have these treatments done without a parent present:
(Please check all that apply)

- ○ Punch/Shave Biopsy
- ○ Blue Light treatment (for acne)
- ○ Cryotherapy/Liquid Nitrogen
- ○ Cantharidine treatment (for Molluscum)
- ○ Excimer laser
- ○ Electrocautery
- ○ Intralesional injection
- ○ NO PROCEDURES SHOULD BE PERFORMED WITHOUT ME BEING PRESENT.

This permission will be in effect until I rescind it in writing. I understand that this directive supercedes any previous directive provided.

Sincerely,

_____ _____ _____
(Signature) (Print Name) (Date)