

## Permission to Treat an Unaccompanied Minor

Child's name \_\_\_\_\_ Date of birth \_\_\_\_\_

I give my permission to have my child treated in my absence by a provider at Hudson Dermatology.

No adult needs to accompany my child.

\_\_\_\_\_ will accompany my child.

Signature of adult \_\_\_\_\_  
in attendance

This consent remains in effect until \_\_\_\_\_  Indefinitely

Parent's name \_\_\_\_\_

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_