

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 _____