OLYMPIC DERMATOLOGY
& Laser Clinic

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ADVANCE CONSENT TO TREAT MINORS

I, ______________________________, the parent or legal guardian of my child, ________________________________, authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will remain in effect until revoked in writing by me.

I authorize the following people to bring my child in for their appointment:

____________________________________ ____________________
Name Relationship to pt.

____________________________________ ____________________
Name Relationship to pt.

____________________________________ ____________________
Name Relationship to pt.

____
Signature of parent/guardian Date

Updated 2/23/2010