Dermatology ASSOCIATES of Northern Kentucky

The Best Doctors in America®
PEER SELECTED 2021-2022

Adult & Pediatric Dermatology • Dermatologic Surgery • Mohs Micrographic Surgery
Laser & Cosmetic Surgery • Dermatopathology

CONSENT TO TREAT PATIENT UNDER 18

I, ____ , parent or legal guardian of

____ (patient),

born ______________________ (D.O.B.) consent to medical or surgical treatment of my child as

deemed necessary or appropriate by the physicians at **Dermatology Associates of Northern Kentucky.**

I understand that treatment could be deferred until such time as I may be able to be present but elect to allow treatment in my absence.

I also understand that, once my dependent reaches the age of 18, my consent for treatment is no longer required.

Signed: ____ ____________

(Parent/Legal Guardian) (Date)

Parent/Guardian Emergency Contacts:

Name _________________________ Phone (Day) ____________ (Eve) _____________

Name _________________________ Phone (Day) ____________ (Eve) _____________

Rev 06/22