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PRE-CONSENT FORM TO TREAT MINORS or PATIENT with GUARDIAN

Purpose: This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services.

AUTHORIZATION:

I hereby appoint: ____
Name Relationship

as a proxy decision maker to consent to and authorize routine health care treatment and services for my child listed below.

I, ____, the parent/guardian of:
Parent/Guardian Name

____
Patient Name and Date of Birth

hereby empower and grant to ***MacInnis Dermatology*** permission to administer medical treatment for the above child/ward. I do hereby indemnify and hold harmless the physician and other persons who act in reliance upon this authorization.

____ ____________________
Print Name of Parent/Guardian Relationship to Patient

____ ___________
Signature Date

This consent expires upon the patient's 18th birthday.