DCM Skin Solutions
CONSENT TO TREAT MINOR CHILDREN

I ________________________, parent or legal guardian of ________________________,

date of birth ___/___/___.

I do hereby consent to any medical care and the administration of local anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of Gennady Chernyak PA-C at DCM Skin Solutions Muncie, Indiana.

This authorization is effective from the ___ day of ________________________, 20___ to

___ day of ________________________, 20___

_______________________________________ ___________________
Signature of Parent or Legal Guardian **Date**

This consent form should be taken with the child to the Dermatology office when the child is taken for appointment/treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address ____

Parent or legal guardian phone: ________________

Child's Physician: ___________________________ Phone: ________________