**ADVANCED DERMATOLOGY and COSMETIC SURGERY**
**PARENTAL**
**TEMPORARY ASSIGNMENT of AUTHORIZATION to TREAT MINOR CHILD**

**MINOR`S FULL NAME_____DOB_____**

**I am aware that my child may require treatment when I am not able to be present. In my absence, I give to _____**
**[Individual name and relationship to patient]**
**my permission to authorize non-invasive medical treatment for my child.**

**This agreement begins_____and ends_____**

**_____ _____ _____**
**Parent/Legal Representative Signature Relationship to patient Date/Time**

**Print Parent/Legal Representative Name**

**_____ _____**
**Witness to Signature Date and Time**

**MEDICAL, PHYSICAL AND INSURANCE INFORMATION**

**Please complete:**

**Weight_____Height_____**

**Allergies_____**

**Medications:_____**

**Previous Surgeries:_____**

**Chronic Illnesses:_____**

**Other pertinent medical information_____**

**Insurance Carrier:_____Policy#_____ID#_____**