Desert Sky Dermatology, PLLC
1688 E Boston Street, #101
Gilbert, AZ 85295
Phone (480) 855-0085
Fax (480) 855-0086

CONSENT TO TREAT A MINOR

NOTE: Parent of legal guardian must accompany a minor child to their first office visit. At that time a photo ID and signed authorization will be obtained from the parent/guardian.

I, the parent/guardian of _____, a minor;

whose date of birth is _____, do hereby allow my child to attend his/her scheduled appointments at Desert Sky Dermatology in my absence. I further authorize the medical providers and staff of Desert Sky Dermatology to both diagnose and treat my child's condition, as needed.

This consent applies to:

- ☐ One visit only, date of _____
- ☐ All future visits, as needed _____
- ☐ Consent expiration _____

_____ _____

Signature of Parent/Guardian Date