CONSENT TO TREAT MINOR CHILDREN

(when seen under someone else's supervision – non parental)

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care determined by Loyd Godwin, MD or other medical provider within Dermatology Physicians of CT to be necessary for the welfare of my child while said child is under the care of _____, and I am not reasonably available by telephone to give consent.

This authorization is effective from _____ to _____.

_____
Signature of Parent or Legal Guardian

_____ _____
Witness Signature Witness Name (please print)

This additional information will assist in treatment if it can be furnished with the consent, but it is not required.

Contact: Mother's name: _____ Phone number: _____

Father's name: _____ Phone number: _____

Allergies to drugs or food _____

_____

Medications or Pertinent Information _____

_____

Primary Care Physician _____