



DERMWELLESLEY

Consent for Treatment of a Minor Child

I, as parent or guardian of Name/DOB: _____,
do hereby request and authorize the physicians and staff of DermWellesley, LLC to perform
necessary services for my child which are deemed advisable by the physician, whether or
not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

Signature of Parent or Guardian

Date

Printed Name of Parent or Guardian

Witness Signature

Date

Printed Name of Witness

**This form should be witnessed by a member of the DermWellesley team. If you are
unable to accompany your child to his or her initial appointment, your signature
must be notarized.**