SUNFLOWER
DERMATOLOGY & MEDICAL DAY SPA

Parental Consent for Medical Treatment

Name of patient: _____

Name of parent or guardian: _____

Age of patient: _____

Patient allergies: _____

Patient medical conditions: _____

I, _____ being the parent or legal guardian of

_____ hereby authorize and give consent to Brian Matthys, D.O., Molly Menser, D.O., Nicholas Rudloff, D.O., Lynn Swafford, P.A., Paige Lovelace, P.A., for medical evaluation and treatment for my child. This permission includes treatment of lesions requiring minor surgical procedures in the office or injections.

Signed: _____ Date: _____

Reviewed by: _____ Date: _____