K DERMATOLOGY
& AESTHETIC CENTER

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# CONSENT FOR MEDICAL TREATMENT OF A MINOR

I, the undersigned parent/guardian, hereby grant Dr. Sairah Khokher and all the licensed staff of K Dermatology & Aesthetic Center to obtain medical evaluation and provide treatment for patient:

_____ _____
(Name of Patient) (Patient's Date of birth)

The above care provider(s) shall have the authorization to:

Obtain medical history and provide medical treatment including procedures such as skin biopsies if needed, for the above patient as deemed appropriate by the medical provider.

In any case of emergency, the care provider(s) will try to contact me first.

This consent is given by me as the parent and/or guardian of said child. I have legal power to consent to medical, psychological and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed to the best of your professional ability.

This grant of temporary authority shall begin on patient's first visit and shall remain effective until terminated by the undersigned.

_____ _____
Signature of Parent / Guardian of Patient Date

_____
Name of Parent / Guardian of Patient