PARKS DERMATOLOGY
C • E • N • T • E • R

CONSENT FORM FOR TREATMENT OF MINOR CHILD

Appointment Date/Time:_____

Provider Name:_____

The State of Florida has enacted a new law that imposes additional obligations on health care providers when obtaining consent to treat a minor child. This form seeks to comply with our obligations under this new law, including obtaining a written consent to prescribe, where medically indicated, medicinal drugs needed by the minor child identified below. The new law also states that written consent must be obtained from a parent who has legal custody of the minor child or is the legal guardian of the minor child.

My signature below represents that I am either a parent with legal custody or the legal guardian of the minor child identified below.

I give Parks Dermatology Center LLC physicians, other licensed medical professionals, residents, and Parks Dermatology Center LLC personnel and contractors consent to provide, solicit and arrange for health care services, and prescribe medicinal drugs when necessary, to the minor child named below.

Minors First & Last Name: _____

Minors Date of Birth:_____

Parent/Guardian First & Last Name: _____

_____ _____

Signature of Parent/Guardian Date

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