

**CONSENT TO TREAT A MINOR CHILD  
IN THE ABSENCE OF A PARENT OR GUARDIAN**

I hereby authorize the physicians and/or physician assistants of Kahn Dermatology, PLLC, to treat my child in my absence.

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

I understand that a separate consent form must be duly executed for each appointment, and that this consent form is only valid for the appointment date entered above.

I understand that no surgical procedure will be performed without a duly executed consent form.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Name (print): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_