Uderm™

Consent for Medical Evaluation and Treatment of a Minor

Patient's Name _____ Date of Birth _____

Signing this form grants Uderm, PLLC permission to evaluate and/or treat the minor patient listed above for the condition(s) of _____ when the minor is *not* accompanied by a parent or legal guardian, or when the minor patient is accompanied by an adult *other than* the parent or legal guardian.

Person(s) who may consent to treatment (please print):

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

May we leave medical information about the minor on your answering machine or cell phone?

☐ Yes ☐ No

Do you give our office permission to discuss medical information about your minor with the person bringing the minor today?

☐ Yes ☐ No

Please list all medications being used by the minor patient:

_____

_____

Allergies to Medications:

_____

_____

Please list any other significant medical conditions of the minor patient:

_____

_____

This authorization is effective from _____ until _____

Signature of Parent or Legal Guardian _____

Printed name _____ Date _____

Parent/Guardian Phone Number _____Witness : _____