DERMATOLOGY ASSOCIATES OF MORRIS, P.A.
199 Baldwin Road
Parsippany, New Jersey 07054
973-335-2560 www.dermatologyassociatesofmorris.com

CONSENT TO TREAT MINORS

I, _______________________, the parent or legal guardian of

_______________________, Date of Birth: _____/______/__________,

Grant permission for my child to be treated at Dermatology Associates of Morris, P.A., Parsippany, New Jersey.

Treatment may include (please check):

[ ] General medical care

[ ] Minor surgery which may be accompanied by the administration of local anesthesia (Lidocaine).

Please list any allergies and/or medical conditions that we should be aware of:

This authorization is effective (please check):

[ ] Today Only _____/_____/________

[ ] From _____/_____/________ to _____/_____/________

At the time of the visit, the parent/guardian can be located at the following phone number:

Name:
Phone Number:

____

Signature of Parent or Legal Guardian (please circle one)