OHIO SKIN CENTER
DERMATOLOGY • SURGERY • COSMETICS

TREATMENT OF A MINOR

Patient Name: _____ Date of Birth: _____/_____/_____

In the event that I am unable to accompany my child to their physician appointment at Ohio Skin Center, I hereby give my permission to the listed names below to accompany the patient in my absence.

Please note any names listed below that will be allowed to accompany your child and make decisions on your behalf.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____/_____/_____

Signature of Parent/Guardian Today's Date

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