
# Minor Consent Form

I, _____, parent/legal guardian of _____, give my consent to the staff of Central Florida Dermatology Associates to see my child without my presence on _____ and for the remainder of the year. I understand it is my responsibility to provide a copy of my valid photo I.D. on the date of service in order for my child to be treated. Please note: The providers have the right to refuse treatment at any time, should it be a case in which the presence of a parent/legal guardian is required.

_____

Signature Date