FLORIDA INSTITUTE
OF DERMATOLOGY

MINOR MEDICAL CONSENT FORM

Child's Information

Child's Full Name: ___________________

Gender: ____________________________

Date of Birth: _______________________

Address: _____________________________

Parent/Legal Guardian Information

I, _________________________, parent or legal guardian of ______________________ do hereby swear and declare that I am the parent, or the legal guardian of the child/children herein listed and that there are no court orders preventing the parent or guardian from granting this authorization.

In case of an emergency, the parent(s) or legal guardian(s) should be contacted at the following:

Name: __________________________________

Address: ________________________________

Phone Number: _________________________

Secondary Phone: ________________________

Email: ___________________________________