Saginaw Bay Dermatology
Parental Consent for Treatment of a Minor

I hereby authorize the providers at Saginaw Bay Dermatology to evaluate and treat my minor child in my absence.

- I understand that I, or an adult guardian, am expected to attend all of my child's appointments whenever possible.
- I acknowledge that having my minor child evaluated and treated, without an adult present, is a courtesy extended by Dr. Boyce and his associates and as such can be revoked at any time, for any reason.

I specifically allow a provider at Saginaw Bay Dermatology to evaluate and treat my minor child for the conditions marked below. Any concerns not indicated below will not be addressed in my, or an adult guardian's, absence.

☐ All conditions ☐ Acne ☐ Psoriasis

☐ Verruca (Warts) ☐ Vitiligo ☐ Eczema

☐ Other: ____

I acknowledge that certain medical conditions and/or therapies may pose significant risk to the health and well-being of my child.

- If my child has such a condition or requires treatments that pose significant risk of side effects, I or an adult guardian will be required to be present at all appointments.
- I understand that under these circumstances my minor child will not be evaluated or treated in the absence of a parent or guardian.

I am aware that my minor child will be sent home with information pertaining to the rendered diagnosis and selected treatment. This information will contain the risks therapy may pose to my child.

- I understand that I may call the office to acquire additional information about the diagnosis and treatments.
- I acknowledge that if the frequency and duration of calls becomes disruptive to Dr. Boyce or his office staff, my minor child will no longer be evaluated in the absence of a parent or guardian.

______________________________ ______________
Patient's Name Date

______________________________ ______________
Patient's Date of Birth Age

______________________________ ______________
Parent or Guardian Signature Date