Greater Knoxville Dermatology, PLLC

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Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

The undersigned parent or legal guardian of _____ authorizes the person(s) listed below to
(Child's Name)
consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to _____.
(Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: _____ Relationship to child: _____ Phone: _____

   Name: _____ Relationship to child: _____ Phone: _____

   Name: _____ Relationship to child: _____ Phone: _____

2. Medical Concerns: _____

3. Known Allergies: _____

Name of Parent or Legal Guardian: _____ Relationship to Child: _____
(Print Name)

Contact Number(s): _____

Address: _____ City, State, ZIP: _____

Signature: _____ Date: _____

This Consent is effective until withdrawn in writing by the child's parent or guardian.

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