



RIVERGATE DERMATOLOGY
& SKIN CARE CENTER

*Diplomat American
Board of Dermatology*

*Fellow American
Academy of
Dermatology*

Consent for Treatment of a Minor

I, _____ hereby give my permission to Rivergate

Dermatology to treat and/or obtain blood/body fluid sample/culture from my child

_____, as deemed necessary by the physician when I,

the parent or guardian, am not present.

This consent form will become a part of the patient's chart, and remains valid and effective

from date of signing until revoked in writing.

Signature/Relationship _____

Date _____