

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 also 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
the parent/ legal guardian is required for treatment.

Sincerely,

Signature

Date