



Minor Consent Form

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
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 a parent/legal guardian is required.

Signature

Date