WESTCHESTER DERMATOLOGY MEDICAL CLINIC

TREATMENT TO MINORS CONSENT FORM

Patient Name:_____ Date of Birth:____/____/____

Children 16 or 17 Years Old:

Minors 16 or 17 years old, MUST have a Parent/Legal guardian present for initial office visit or they will be asked to reschedule their appointment. If the patient is 16 or 17 years old, they can be seen for follow up appointments without a Parent/Legal guardian **only** if Parent/Legal guardian fills out and signs this consent form authorizing **Westchester Dermatology Medical Clinic** and **Sherri Peace, MD** to provide treatment to their teen.

I hereby grant Westchester Dermatology Medical Clinic and Sherri Peace, MD permission to treat my 16 or 17 year old teen when they arrive at the office unaccompanied on:

_____ **until** _____

Date of Permission End Date of Permission

TO BE SIGNED IN OFFICE _____ _____/_____/_____

Signature of Parent/Legal Guardian Date

Children 15 Years Old or Younger:

Minors 15 years old and younger, MUST have an adult present for all office visits or they will be asked to reschedule their appointment. If the patient is 15 years old or younger, they will be able to be seen for their appointment with an adult present other than a Parent/Legal guardian **only** if Parent/Legal guardian fills out and signs this consent form authorizing **Westchester Dermatology Medical Clinic** and **Sherri Peace, MD** to provide treatment to their child.

I hereby grant Westchester Dermatology Medical Center and Sherri Peace. MD permission to treat my child when they arrive at the office accompanied by the authorized named adult listed below.

_____ _____

Name of Authorized Adult Relationship to Patient

_____ until _____

Date of Permission End Date of Permission

TO BE SIGNED IN OFFICE _____ _____/_____/_____

Signature of Parent/Legal Guardian Date