San Luis Dermatology & Laser Clinic, Inc.
15 Santa Rosa Street – San Luis Obispo, CA 93405
1551 Bishop Street, Suite 410 – San Luis Obispo, CA 93401

AUTHORIZATION FOR TREATMENT OF A MINOR

IN THE ABSENCE OF THE PARENT

Date:_____

Minor's Name:_____DOB:_____

I_____
(**Print** Minor's Parent Name)

am aware that my child may require treatment when I am not able to be present. In my absence, I

give _____DOB:_____
(**Print** Individual name)

_____, _____
(**Print** relationship to the patient) (Driver's License or other **ID** number)

my permission to schedule, transport to and authorize medical treatment for my child.

I hereby give permission to ☐R. Jeffrey Herten, M.D. ☐Michael P. Heffernan, M.D. ☐ Joseph W. Diehl, M.D. ☐ Charles B. Fishman, M.D. ☐ Cheryl Ketelsen PA

to examine and provide treatment to my child.

_____	_____	_____
Print Parent/Legal Representative Signature	**Signature** Parent/Legal Representative	Relationship to Patient
_____	_____	_____
Print Authorized Parent Representative Name	**Signature** Authorized Parent Representative	Relationship to Patient
_____	_____	
Witness to Signature	Date/Time	

This agreement begins_____and ends_____