Greater Knoxville Dermatology, PLLC

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Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

The undersigned parent or legal guardian of __________________ (Child's Name) authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to _________________ (Phone Number).

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: _________________________ Relationship to child: __________ Phone: __________

   Name: _________________________ Relationship to child: __________ Phone: __________

   Name: _________________________ Relationship to child: __________ Phone: __________

2. Medical Concerns: ____

3. Known Allergies: ____

Name of Parent or Legal Guardian: ___________________________ (Print Name) Relationship to Child: _______________

Contact Number(s): ____

Address: ____ City, State, ZIP: _______________________

Signature: ____ Date: _____________

This Consent is effective until withdrawn in writing by the child's parent or guardian.

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