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Jared Scott, MD
Jessie Zimmerman, PA-C
Brittney Irons, FNP-C
Jeanna Rendo, NP-C
Katelyn Wade, PA-C

Authorization for Treatment to Minor

Minor's Name in Full	
Date of Birth	Medical Record Number

I/We the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the physicians of Idaho Skin Surgery Center, PC. to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to: examination, preventative and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgement as to the requirements of such diagnosis or medical treatment in my/our absence.

NOTE: Not used as permission for vaccines.

This consent shall remain in effect until revoked in writing, by parent(s) or legal guardian(s), or until child may legally consent for him or herself.

Signature-Parent or Legal Guardian	Date
Witness	Date

I declare under penalty of perjury under the laws of the state of Idaho that the forgoing is true and correct.

Signature	Date

County of ______________________)

State of ________________________)

Subscribed and sworn to before me on this _______day of _______________________, 20 _____.

Notary Public

NOTARY STAMP

____

Commission No.

____

Commission Expires

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