FAIRHURST DERMATOLOGY
3040 BUSINESS PARK CIRCLE
GOODLETTSVILLE, TN 37072
615-870-1404 FAX 615-870-1454

PERMISSION TO TREAT A MINOR

(THIS IS DEFINED AS UNDER THE AGE OF EIGHTEEN-18)

I hereby give permission to the physicians, physician assistants, and nurse practitioners of Fairhurst Dermatology to perform treatment, surgical, medical, or diagnostic procedures emergent or non-emergent, that would be necessary to treat my child _____, for his/her condition.
(Name of Child)

I understand that I or another responsible and knowledgeable adult accompany my child for routine care. If this is not possible with teenagers, I hereby consent to their treatment without a parent being with them.

This permission slip will be used in addition to making an effort to contact parents or legal guardian in the case of an emergency.

Fairhurst Dermatology reserves the right to make drug testing of minors, whether requested by the parent or an employer or prospective employer, available to the parent or guardian.

The physicians of Fairhurst Dermatology reserve the right to discuss the results of all testing and treatment with the parents of the minor when the physician feels this is necessary for the best care of the minor.

Signed_____ Date _____
Parent or Guardian

Relationship_____

Witness_____ Date _____