SOMA
Skin & Laser

CONSENT TO TREAT MONOR

Patient Name: _____ **Date of Birth:** _____

I certify that I hereby authorize SOMA Skin & Laser, its providers and staff to provide my minor child in my absence with examinations and basic treatment for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which require separate consent such as surgery, biopsy, or wart destructions. I understand additional written consent may be necessary for these types of procedures ant that the legal guardian must be present for such consent.

Signature of Patient/Parent/Guardian:_____ Date:_____