DERMATOLOGY CENTER
STEAMBOAT SPRINGS

940 Central Park Dr Ste 210
Steamboat Springs CO 80487
Office: 970.871.4811
Fax: 970.879.4527

CONSENT TO AND DIRECTION FOR TREATMENT OF MINOR

Child's Full Legal Name _____ Child's Date of Birth _____

1. **Authorization and Consent.** I (We), being the parent(s) or guardian(s), entitled to the care, custody and control of the above minor, do hereby authorize, request and direct you to render such treatment to said minor, including without limitation diagnostic, medical, minor procedures, and venipuncture.

2. **Unaccompanied by Parent/Guardian.** This consent to treatment is given in contemplation that the above minor may from time to time appear at Dermatology Center of Steamboat Springs medical offices and affiliated clinics, for examination or treatment or both, unaccompanied by an adult, custodial parent or non-custodial parent, because of my (our) absence or unavailability. I (We) hereby authorize, request and direct you to render treatment to said accompanied minor, including without limitation diagnostic, medical, minor surgical care, x-rays, venipuncture and other care that requires a series of treatments to the extent that I (we) have previously consented to the series of treatments.

3. **Parent/Guardian Participation.** I (We) understand that at times the physicians, physician assistants, nursing staff or administrators may deem it advisable that a parent or guardian or other authorized adult be present with said minor for the purposes of assisting in the diagnosis or treatment. I (We) agree to cooperate by being present with said minor at all times possible or when requested.

4. **Substitution Decision Maker.** I (We) hereby grant authority to the following adult(s) to consent to care for my minor child should I not be available to provide consent at Dermatology Center as allowed by Colorado Revised Statute (C.R.S.) 15-14-105, subject to the following limitations, unless prohibited to law:

Name: _____ Telephone Number: _____ Relationship to Minor: _____

Street Address: _____ City, State, Zip Code: _____

Name: _____ Telephone Number: _____ Relationship to Minor: _____

Street Address: _____ City, State, Zip Code: _____

☐ All non-emergent, non-major care.

☐ Limited treatment, condition(s), procedure(s), and or treatments (e.g., treatment of warts, biopsy of skin lesions/moles, acne treatment, etc.) _____

_____

☐ Please contact me in the event a medical decision needs to be made for additional, unanticipated medical services beyond the reason for the patient's visit.

5. **Expiration or Termination.** All aspects of this consent will be in effect until specifically terminated or modified by written notice received by Dermatology Center of Steamboat Springs at the above address or on the date the minor becomes an adult under state law.

Signature of Parent or Guardian	Signature of Parent or Guardian
Relationship to Minor	Relationship to Minor
Date	Time

Note to Parent or Guardian: This form should be completed for each minor in the family and filed with Dermatology Center of Steamboat Springs.