

I, being the parent or guardian of \_\_\_\_\_, do hereby request and authorize the physicians and staff of *Dermatology Specialists of Pasadena* to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment. Below is a list of individuals who have permission to bring my child in for treatment:

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\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Patient DOB: \_\_\_\_\_

*\*This form should be witnessed by a member of the Dermatology Specialists of Pasadena Staff. If you are unable to accompany your child to his/her initial appointment, your signature must be notarized.*