SPOKANE DERMATOLOGY CLINIC

3RD & SHERMAN MEDICAL PLAZA

324 SOUTH SHERMAN STREET

SPOKANE, WASHINGTON 99202

(509) 624-1184

Consent to Treat Minors

I, _____, the parent or legal guardian of my child, _____, authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

_____

Signature of parent/legal guardian *Date*