Dermatology Associates of Coastal Carolina

Consent to Treat a Minor

Patient Name: _____ Date of Birth: ____/____/____

If I am unable to accompany my child to their physician appointment at Dermatology Associates of Coastal Carolina, I give my permission to the listed names below to accompany the patient in my absence. Please note names listed below will be allowed to accompany, and make decisions on my behalf.

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

_____ ____/____/____

Signature of Parent/Guardian Today's Date

Kinston, NC 28501
Phone: (252) 686-0991
Fax: (252) 686-6810

Morehead City, NC 28557
Phone: (252) 622-4378
Fax: (252) 622-4659

Jacksonville, NC 28546
Phone: (910) 333-9337
Fax: (910) 333-8607

New Bern, NC 28560
Phone: (252) 633-4461
Fax: (252) 633-6016