

**SOUTH SHORE SKIN CENTER**  
One Scobee Circle, Plymouth, MA 02360  
223 Chief Justice Cushing Hwy, Cohasset, MA 02025

**PARENT/GUARDIAN AUTHORIZATION TO TREAT MINOR CHILD**

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Date of Appointment \_\_\_\_\_

**Parent/Guardian Complete the Following**

I, the undersigned parent/legal guardian, of the minor named above do authorize the physicians and/or physicians assistants of South Shore Skin Center to provide healthcare services to this minor in the absence of a parent or legal guardian. I understand that the healthcare services may include, but are not limited to: examination, medical or surgical diagnosis, local anesthetic, and preventative and/or curative treatment.

State any restrictions or exceptions: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Name (please print or type)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Telephone Number where you can be reached at the time of the minor's appointment:

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Please fax completed form to: 508-746-9265 (Plymouth office) or 781-383-3341 (Cohasset Office) or mail to one of the above office addresses, or have your child bring it with him/her to the appointment.