Gem State Dermatology, P.A.
388 E. Parkcenter Blvd. Boise, ID. 83706
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MEDICAL TREATMENT AUTHORIZATION FOR A MINOR		
Minor's Full Name: Last, First, M.I.	DOB	Age
Name(s) of Parent or Legal Guardian		

I/We the parent(s)/legal guardian(s) of the minor listed above hereby authorize the physician(s) and/or physician assistant(s) at Gem State Dermatology to provide health services to this minor in the absence of a parent or legal guardian. These services may include but are not limited to examination, evaluation, xrays, laboratory studies, anesthetic administration, treatment (preventative and/or curative) and any consultation deemed necessary at the providers discretion.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician/physician assistant to exercise his or her best judgment as to the requirements of such diagnosis or medical treatment in my/our absence.

This consent will remain in effect until revoked in writing by parent(s) or legal guardian(s), or until child may legally consent for him or herself.

Signature of Parent/Legal Guardian	Date
Signature of Parent/Legal Guardian	Date
Witness	Date