SUNFLOWER

dermatology & day spa

Brian Matthys, D.O.
1805 NW Platte Rd, Suite 120, Riverside, MO 64150
816-472-0400 • Fax: 816-472-0813

PARENTAL CONSENT FOR MEDICAL/SURGICAL TREATMENT

Name of Patient: ____

Name of Parent/Guardian: ____________________________________

Age of Patient: ______________

Allergies: ____

Medical Problems: ____

____

I, ____ being the parent or legal guardian of ___________________________________ hereby authorize and give consent to Brian Matthys, D.O./Jennifer Ashby, M.D. for medical evaluation and treatment for my child. This permission includes treatment of lesions requiring minor surgical procedures in the office or injections.

Signed: __________________________________ DATE ________________

This form may be brought with the child to the office or sent in advance and to be kept on file