Authorization for Care to Minor(s)

I/We, the undersigned parent(s) or legal guardian of the minor listed below:

Minor's Name: _____ Date of Birth: _____
do hereby authorize any medical diagnosis or treatment by any Wolverine Dermatology Provider (Physician or delegated staff) licensed in the State of Michigan and services that may be rendered to said minor under the general, specific, or special consent of: _____
(name of person being given temporary authority) the temporary Custodian of minor.

I/We authorize the Provider to call in any necessary consultants, at their decision. We further authorize said Provider to exercise their discretion in authorizing the disposal of any severed tissues or member.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but it is given to encourage those persons who have temporary custody of the minor and said Provider to exercise their best judgement as to the requirements of such diagnosis or medical treatment.

This consent shall remain effective until _____am/pm on the day of _____
20_____ unless sooner revoked in writing, delivered to said Provider or said persons entrusted with custody, care, and control of said minor child.

Parent/Legal Guardian Signature: _____

Signature Date: _____

Relationship to Patient: _____

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