

l,	, parent or legal guardian of		
	, bc	orn	, do
hereby consent to any medical care determin	ed by a physicia	n at Fairfield Derma	tology to be necessary
for the welfare of my child when I am not rea	sonably availabl	e by telephone to gi	ve consent. This
authorization is effective from	to	·	
Signature of Parent or Legal Guardian			