



I, \_\_\_\_\_, parent or legal guardian of  
\_\_\_\_\_, born \_\_\_\_\_, do  
hereby consent to any medical care determined by a physician at Fairfield Dermatology to be necessary  
for the welfare of my child when I am not reasonably available by telephone to give consent. This  
authorization is effective from \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_  
Signature of Parent or Legal Guardian