



Alamo Oaks Dermatology

Shanny A. Baughman M.D.

Certified by the American Board of Dermatology

General and Aesthetic Dermatology –Mohs Surgery

I/We the undersigned guardian (s) of _____ Date of Birth _____
(Child's Name)

_____ hereby give permission to the following relative and/or caregivers to bring my/our child to his/her doctor's visit(s):

_____ hereby give permission for the above minor to be seen by themselves at Dr.'s visits

Name (please print)	Relationship to minor (please Print)

EMERGENCY NAMES AND NUMBERS

1. Name (please Print) _____ Phone _____

Relationship to Child _____

2. Name (Please Print) _____ Phone _____

Relationship to Child _____

X _____
Name/Legal Guardian Signature Relationship Date

X _____
Name/Legal Guardian Signature Relationship Date