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

3189 Danville Blvd, Suite 130 Alamo, CA 94507 o 925.362.0992 f 925.362.0979 www.alamooaksderm.com