

NORTHEAST TARRANT DERMATOLOGY, INC.

**Tho Q. Nguyen, M.D.
Douglas R. Farris, M.D.
Stacy R. Beaty, M.D.**

Treatment of a Minor

Please print all information until signature.

Name of Minor Patient: _____

Parent/Guardian Name: _____

Parent/Guardian Contact Number: _____

Any Known Allergies: _____

Since I will not be present in the office, I am giving written consent for the above listed minor to receive medical treatment at Northeast Tarrant Dermatology (NETD) from this date forward. This treatment may include in-office procedures and prescriptions. At any time, this authorization may be revoked in writing and given to NETD.

Signature of Parent or Guardian: _____

Date consent begins: _____