JEFFREY G. MOSKOWITZ, M.D.
Board Certified Dermatology

ELANA SHACKELFORD, A.P.R.N.
BROOKE GREGORY, A.P.R.N.
ALICIA NUÑEZ, A.P.R.N.

143 Mission Road, Oviedo, FL 32765
(407) 542-0100

CONSENT TO TREAT MINOR CHILDREN

I, _____ , parent or legal guardian of _____ , born the _____ day of _____ do hereby consent to any medical care and administration of local anesthesia determined by M.D./A.P.R.N. while my child is under the care of Moskowitz Dermatology of 143 Mission Road, Oviedo, FL 32765. This authorization is effective from today _____ to _____ which is one year.

_____ _____
Signature of Parent or Legal Guardian Date

This form may be typed and electronically signed, or printed and signed by hand.