



### Consent for Treatment of Minors

I understand that I am legally required to be present for the first visit of my child or any minor under my care, under the age of 18. I hereby authorize Nova Dermatology and Sandra Kopp, MD to continue evaluation, diagnosis and treatment of my child, dependent or foster child without my presence in the office after the first visit. I consent to in-office procedures for my dependent minors that include, but are not limited to, cryotherapy, cautery, biopsies and injections which are deemed advisable by Dr. Kopp. I understand that while this authorization shall remain in effect, effective immediately and indefinitely, I may revoke this authorization at any time and for any or no reason by submitting a written request to the office.

Below is a list of individuals who have permission to bring my child in for treatment:

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

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

\_\_\_\_\_  
Date