DEPARTMENT OF DERMATOLOGY

Child's Name: _____

Child's Date of birth: _____ / _____ / _____

I, _____ the parent or guardian give permission to the following person or persons to bring my child to Stony Brook Dermatology Associates and make medical decisions and allow vaccinations during the visit.

Name: _____Relationship to patient: _____

Name: _____ Relationship to patient: _____

This letter will be valid for up to six months from the date indicated above, unless otherwise updated.

Date:_____

Parent Name:_____

Signature of parent:_____

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