

# Advanced \* Dermatology

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Date: \_\_\_\_\_

I, \_\_\_\_\_ (print your name), give permission for  
\_\_\_\_\_ to examine and prescribe treatment  
for \_\_\_\_\_ (acne, warts, rash, etc.) for the minor  
\_\_\_\_\_ (patient's name) in my absence.

\_\_\_\_\_ (Signature)

\_\_\_\_\_ (Relationship)