

**JAMES BOND JR., M.D., P.A.**

**DERMATOLOGY**

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**AUTHORIZATION TO TREAT MINOR CHILD(REN)**

I authorize Dr. James R. Bond, Jr., and/or his staff, to medically treat my  
minor child(ren) \_\_\_\_\_

For the following medical condition(s):

\_\_\_\_\_  
\_\_\_\_\_

I am giving this authorization because I am unable to be present when my  
child(ren) is/are being treated by Dr. Bond.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date