



I hereby authorize Dr. Betty Rajan or other healthcare providers at Betty Rajan, MD to  
treat my child \_\_\_\_\_ today and when I am not present.

If a surgical procedure needs to be performed for any condition other than acne and warts,  
I will be contacted beforehand. I hereby acknowledge that all my questions have been  
answered about this formality and agree to this consent.

\_\_\_\_\_  
Patient or Guardian (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Guardian (Signature)