銀座コクリコクリニック

未成年者の手術とレーザー治療に関する同意書

私は、私の子である（または私の保護下にある）（患者名）＿＿＿＿＿＿＿＿＿＿　が、（施術名）＿＿＿＿＿＿＿＿＿＿＿＿の{　手術・レーザー治療・施術　}を受けるにあたり、貴院の医師により麻酔を含む施術について充分な説明を受けました。

また、（患者名）＿＿＿＿＿＿＿＿＿＿　が署名した同意書についても了解し、疑問点についてもすべて質問し納得しました。施術前後の管理が大切であることや、これを怠ることで不都合が生じることも理解しています。

したがって、医師をはじめとする貴院看護スタッフの指示する注意事項を遵守し、貴院への経過を正確に報告することをお約束し、ここに治療契約を結ぶことに同意いたします。

銀座コクリコ美容外科　殿

２０　　年　　月　　日

署名＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿㊞

Parental Consent for Minor's Surgery

I, _____, declare that;

- I am the _____ (father/ mother) of _____, a minor, age _____, and I have full custody and control of the minor.
- The physician has determined that the operation or procedure listed below may be beneficial in the diagnosis or treatment of my child's condition.
  Operation or procedure to be performed: _____
- I hereby consent to a procedure to be performed on the minor, on or around _____ (Date), by _____ (Physician).
- I hereby consent that preceding, during, and following the procedure, this physician may perform any other treatments deemed necessary or desirable in order to achieve the purposes specified above or to correct any unexpected complications the physician may encounter during the procedure.
- I hereby consent to the administration of any anesthetic that may be deemed necessary by this physician.
- I have been given the opportunity to ask questions about the benefits and risks of the treatment. I understand that no guarantees about results have been made.

I agree that I will thoroughly observe precautions given by my physician or his/her staff strictly, report on my child's process after the procedure, and agree to this contract for my child's treatments.

_____

Name of Child

_____

Parent's or Legal Guardian's Signature

_____

Date