

CONSENT FOR TREATMENT OF A MINOR CHILD

Accompanied by an adult other than parent or legal guardian

I, _____
(parent or legal guardian)

Authorize _____ to treat the following child/children:

Name & Birthdate:
Name & Birthdate:
Name & Birthdate:
Name & Birthdate:

For routine and emergency dental treatment when deemed necessary by qualified dental personnel when accompanied by:

Name and Relationship:
Name and Relationship:
Name and Relationship:

This authorization is valid for one (1) year from the date signed unless otherwise specified in writing.

Printed Name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Date