AUTHORIZATION FOR MINOR CHILD ACCOMPANY

Child #1 Full Name:_____ DOB:_____

Child #2 Full Name:_____ DOB:_____

Child #3 Full Name:_____DOB:_____

Child #4 Full Name:_____DOB:_____

I,_____ give _____ and_____

(Parent or Legal Guardian) *(Authorized Person' Full Name)* *(Authorized Person' Full Name)*

permission to accompany my child(ren)to the office of Flanders Pediatric Dentistry for dental appointments. I also give permission to _____and _____

(Authorized Person' Full Name) *(Authorized Person' Full Name)*

to make necessary decisions regarding dental treatment for my child(ren) including, but not limited to:

*The consent to updating Medical History of the Child(ren)

*Emergency or urgent care when I cannot be reached.

*Routine dental care, which may include, dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays and any and all other treatment previously discussed and agreed upon by the parent/legal guardian.

*The consent for the authorized person to discuss my child(ren)'s dental findings, future dental treatment needs and any pertinent health information.

I can be reached at the following number if there are any questions: _____

_____ _____ _____

Signature of Parent/Guardian Relationship to Patient Date