Consent for Treatment to Minor Child

Date: ______________________________

My child, ___________________________, age______ has permission to have necessary dental treatment performed. This treatment may include, but is not exclusive of:

- Dental radiographs
- Fluoride treatment
- Panoramic – full mouth set of x-rays

Health History changes are: ____

Date of Last Physical: ____

Weight: _______lbs.

Health conditions (surgery, illnesses, or injuries since last dental visit):

____

____

Medications:

(Include over the counter medications and herbal remedies.)

Name	Dosage	How often	Time of day taken

Name of Physician(s): ____

Phone(s) #: ____

I do ☐ or do not ☐ have any dental concerns. If you do have concerns, please describe them below:

____

____

____

Parent/Guardian Signature