Non-Parent/Guardian
Authorization for Consent to Medical Care and Treatment

I, the undersigned, as parent or legal guardian for:

Child's Name ________________________________ Date of Birth __________________

Child's Name ________________________________ Date of Birth __________________

Do hereby authorize and grant the following individual(s) the authority to give informed dental consent for any and all dental procedures or treatments deemed necessary for the well-being of any minor child(ren) named above.

Name ______________________________________ Phone ________________________

Address ____

Relationship to Child(ren) ________________________________

Name ______________________________________ Phone _________________________

Address ____

Relationship to Child(ren) ________________________________

This authorization is for:

___ Today's date only.

___ A specific date of: __________________

___ All future visits effective for one (1) year from today's date.

I realize that it is my duty to update and notify the Health Department of any necessary changes that must be made to this document within a timely manner. I also understand that to ensure this document is accurate, I will be required to complete it annually.

Parent/Guardian ____

Signed this _________ day of ___________________, 20______

Witness ____

STATE OF FLORIDA/ ____________________ COUNTY

Before me, the undersigned authority, appeared the above parent/guardian, who being duly identified signed this instrument in my presence this __________ day of ______________________, 20________.

Notary Public _________________________________ My commission expires: ______________________