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

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

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

do hereby authorize and grant the below named individual(s) the authority to give informed medical consent for any and all dental procedures or treatments deemed necessary for the well-being of my 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.
- □ All future visits effective for three (3) years 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.

Parent/Guardian _____

Signed this _____ day of _____, 20_____

Witness _____ DocuSigned by: Leslie Strickland 2EEA6BBA2CCF48C...

Witness _____