LE CENTER
Dental Clinic

Parent/Legal Guardian Consent for Dental Treatment

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Parent/Legal Guardian Contact Phone Number

Authorized Caregiver's Information

_____ _____ _____
Caregiver's Name Home Phone Number Cell Phone Number

The above name caregiver shall be authorized to consent for all dental treatment, for the above named child(ren), which may be required during my absence. I agree to pay for all services provided to my child(ren) that the caregiver authorized.

If circumstances permit and/or Le Center Dental Clinic needs to contact me, please contact me at the following telephone number:
_____

This consent serves as permission for treatment by Le Center Dental Clinic for the above named child(ren). This authorization shall be effective until:

_____: One (1) year from date signed
Parent/Guardian's Initials

OR

Until _____ (list Month, Day, Year)

This authorization will remain in effect until the date stated above – unless I revoke this authorization in writing and submit it to Le Center Dental Clinic prior to this date

Signature

_____ _____
Parent/Legal Guardian (circle one) Date

_____ _____
Witness Date

***** Note: Consents are NOT required in emergency situations.**