DATE__________

CONSENT FOR TREATMENT

I am the (parent or guardian) of __________________ , who is a minor child, and I authorize any necessary treatment by or under the supervision of Dr. _____________.
I understand that this means taking any necessary radiographs, use of local anesthetic, and use of appropriate medicaments and materials for such treatment.

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION THAT WAS GIVEN TO ME VERBALLY.
BY SIGNING THIS FORM, I GIVE CONSENT TO THE TREATMENT THAT WAS DESCRIBED.

PARENT SIGNATURE _________________________________

WITNESS SIGNATURE ________________________________