PARENT CONSENT

I _____ , give University Dental Associates permission to treat my child without a parent/guardian present.

I _____ , give University Dental Associates permission to treat my child with family member and/or friend _____ , without a legal guardian present.

Child's Name: _____

DOB: _____

Parent / Guardian: _____

Relationship: _____

Phone number to contact in case of an emergency during visit: _____

Reason patient is being seen: _____

Person taking the phone call: _____

Witness Signature: _____

Date: _____

For long term purposes only

Parent/Guardian Signature _____ Date _____