



**Consent for Treatment by an Adult Other Than  
Parent or Legal Guardian**

This consent allows parent(s) or legal guardians to designate another adult, (for example, a grandparent or other relative or adult 18 years or older) into whose care the minor patient has been temporarily entrusted, in order to bring their child in for their dental visit if parent(s) or legal guardian(s) are unable to be present at the appointment.

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Name of Adult Designee: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

The above named person has my permission to bring my child to his/her scheduled appointment(s). I authorize Dr. Angela Willox and/or her staff to perform on my child any necessary or routine dental treatments, including examinations, cleanings, fluoride, dental x-rays, anesthetic injections, nitrous oxide administration and restorations and/or extractions if necessary. I understand that in unusual circumstances efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of a minor is rescinded.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_