



**CONSENT FOR NON-PARENT/GUARDIAN TO BRING MINOR CHILD TO APPOINTMENT**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am the parent or guardian of \_\_\_\_\_ (legal name of patient).  
I have the legal right to consent for dental/medical treatment for this child (patient).

I authorize the following individual, who is a person over 18 years of age and whose relationship to the child is:

\_\_\_\_\_  
(Person bringing child to appointment)

\_\_\_\_\_  
(Relationship to child)

to bring the child to his or her appointment, and to consent to dental care which is deemed necessary by Dr. Hester. I understand that this delegation includes receiving health information about the minor in order to make immediately necessary health care decisions.

**This consent is valid until revoked in writing by me, the parent or legal guardian.**

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Contact information for parent/guardian: \_\_\_\_\_

\_\_\_\_\_  
Phone Number