TREATMENT OF MINOR CHILD AUTHORIZATION FORM

I, _____ (printed name of parent /guardian) give permission for my child _____ (printed name of child being treated) to be seen at Bushnell Family & Cosmetic Dentistry on _____ (date of appointment) for the following treatment:

_____

_____

_____

_____

_____

_____

_____

_____

(please list all treatment that is scheduled to be performed).

Furthermore, I give permission for _____ (printed name of person bringing child to appointment) to bring my child to their appointment and make any necessary decisions for my child if they should arise during the procedure.

_____ _____

Signature of Parent/Guardian Date