

Dental Health Center - Wilmington Campus

PARENTAL AUTHORIZATION FORM FOR DENTAL CARE

I certify that I am the mother/father/legal guardian of _____
(circle) (patient's name/age)
on behalf for whom I am giving this informed consent for cleaning, fluoride
treatment, x-rays (if indicated) and sealants (if indicated).

I understand that the parent/legal guardian must be present **except** when the
child:

- is age 16 and over
- is accompanied by a responsible adult other than his/her
parent/legal guardian (When applicable, note name of designated
responsible adult
here: _____)
- the parent/legal guardian is a Wilmington campus DTCC employee
who will be at his/her job site and available by telephone.

Initial _____

Initial _____

In my absence, I also authorize the provision of dental hygiene treatment to
my child. If my child is accompanied by a responsible adult, I give permission for
this person to sign the Treatment Plan, Informed Consent Form and Patient
Completion and Referral Form.

In case of additional questions and/or emergency, I can be reached at

Daytime Phone #

Signature of Patient/Parent/Legal Guardian

Date

Witness/Designated Responsible Adult