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

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**

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Witness/Designated Responsible Adult