Frederick Pediatric Dental Associates

Power of Consent Form

I, _____, the parent or legal guardian of (Name of Parent or Legal Guardian)

_____, authorize the individuals (Name of Child/Children)

below to accompany my child/children to visits and consent to necessary dental exams and/or treatment and disclosure of dental information regarding the initial and/or follow-up care of my child/children during the visits.

_____ _____

(Name of person Bringing child other than parent) (Relationship to child)

_____ _____

(Name of person Bringing child other than parent) (Relationship to child)

_____ _____

(Name of person Bringing child other than parent) (Relationship to child)

The person(s) named above may consent to the examinations and treatment for my child.

This authorization/consent is effective on this, _____ day of _____, 20____. This Document is effective until revoked by me in writing to Frederick Pediatric Dental Associates.

_____ _____

(Signature of Parent/Legal Guardian) (Printed Name of Parent/Legal Guardian)