Consent For Treatment

I am the (parent or guardian of _____(name of child) who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Dr. _____. This includes exposure of radiographs as necessary, use of local anesthetic reasonable restraint as needed, and use of appropriated medicaments and materials for such treatment.

*****I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEM ME VERBALLY. BY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.**

Parent Signature_____ **Date**_____

Witness_____ **Date**_____