

Dentistry for Your Total Health

Minor Child Medical Consent Form

Date				
I.				
Ι,	(Printed Name	e of Parent or Leg	al Guardian)	
	(Signature	of Parent or Legal	Guardian)	
		_	,	
grant authoriza	ation to the pers	son or persons	listed below, t	o make medical
decisions for				on my behalf
	(P	Print minor's name	?)	