## Authorization for Treatment of Minor in Absence of Parent/Guardian

Regarding: Child(ren) Name: _____

Date of Birth: _____

Adult Caregiver (Babysitter):

Name: _____

Address: _____

Home Phone #: _____ Daytime Phone #: _____

Relation to Child: _____

1. I, the undersigned parent or guardian of the child named above, give permission to the adult named above to act on my behalf to consent to any x-ray examination, anesthetic, sedative medication, medical/dental procedures, or surgical diagnosis or treatment and emergency medical care which is deemed advisable by, and is supervised by, any doctor affiliated with Young Smiles Dentistry.
2. In addition, if my child appears at your office unaccompanied by me or the adult named above, I request and authorize you to treat my child as necessary, including diagnostic, medical/dental and surgical procedures.
3. The authorization shall remain in effect until it is terminated by written notice received by Young Smiles Dentistry or upon the child's attainment of the age of 18 years.

_____

Signature Print Name

By typing your name above, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this Agreement.

_____

Relationship to minor Date