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ALTERNATE GUARDIAN CONSENT

Parent/Legal Guardian Full Name: _____

I cannot accompany my child(ren) to Trinity Pediatric Dentistry.

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

I give permission for the person(s) indicated below to bring my child(ren) to his/her dental appointment which may include exam, cleaning, x-rays, fluoride treatment, sealants, fillings, and extractions.

Authorized Guardian Name: _____ Relationship to Child: _____

Permission is for:

- ☐ This date only: _____
- ☐ For this date _____ and until I notify you otherwise

Parent/Legal Guardian Signature: _____ Date: _____

Notary Signature: _____

Cell Number: _____

Home Number: _____

Email: _____