

## Consent for Treatment

I am the (parent or guardian) of \_\_\_\_\_, who is a minor child, and I authorize the necessary examination and treatment by or under the supervision of Dr. \_\_\_\_\_. This includes, but is not limited to, exposure of radiographs as necessary, application of local anesthetic, and use of medication and materials for treatment.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

*This sample document contains information that you may use or modify for your practice's needs. Your needs may vary based upon the laws in your state. This document does not constitute legal advice.*