

**PARENTAL/LEGAL GUARDIAN CONSENT FORM**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Legal Guardians Name Minors Name**

**do hereby give permission to Chelsie Todd, DMD to provide treatment as**

**necessary on the above named minor child on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**



**Permission to Bring**

**I give my permission for the following individuals to bring my child to his/her appointments with Carson Kids Dental. I also consent to treatment authorized by said individual if treatment is deemed necessary for the oral health of my child:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**