Consent For Treatment of Minors Without A Parent/Guardian Present

I, _____ give permission for my child,
(Parent's or Guardian's name)

_____ to be treated at Park South Dental PLLC
(Child's name)

without my presence. I am updating my child's Medical History and confirming that he/she does not have any heart problems (i.e., heart murmur) or any allergies to medications (i.e., Penicillin). I can be reached at _____during and
(Phone Number)

for the duration of the appointment my child has scheduled.

_____
(Signature of Parent/Guardian)

_____
(Date)