

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

SUBSTITUTE GUARDIAN WHO CAN BRING MY CHILD TO CLINIC

As the parent or legal guardian of:

Child's Name: _____ **Child's Date of Birth:** _____

In the event of my absence, the following individual(s) who is (are) at least 18 years or older has (have) my permission to bring my child to the Florida Department of Health in Walton County (DOH-Walton) Dental Clinic for services. I give my consent for the individual(s) to authorize dental treatment for my child. This includes, but is not limited to X-rays, cleanings, sealants, fillings, root canals, tooth extractions (removal), local anesthesia, and nitrous oxide sedation. This individual (substitute) must furnish a picture I.D. at the time of check in. I also understand that I must revoke this consent by coming in personally to the clinic or by furnishing in writing a copy to the DOH-Walton Dental Clinic that I wish to revoke this consent.

Printed Name of Substitute: _____ **Relationship to Child:** _____

Date Added: _____ **Date Removed:** _____

Parent / Guardian Signature: _____ **Parent Phone #:** _____

Witness Signature: _____ **Date:** _____

Printed Name of Substitute: _____ **Relationship to Child:** _____

Date Added: _____ **Date Removed:** _____

Parent / Guardian Signature: _____ **Parent Phone #:** _____

Witness Signature: _____ **Date:** _____

Printed Name of Substitute: _____ **Relationship to Child:** _____

Date Added: _____ **Date Removed:** _____

Parent / Guardian Signature: _____ **Parent Phone #:** _____

Witness Signature: _____ **Date:** _____