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:** ___________________________