Volunteer Supported, Grant & Donation Funded Dental Clinic
Serving Eligible Children in Green & Lafayette Counties in Wisconsin
411 22nd Ave, Monroe, WI 53566 | 608-328-9404

Consent to Treat Patient without Parent/Legal Guardian Present Authorization

I have the legal right to preauthorize *Fowler Dental Clinic* and its personnel to deliver dental treatment and services to my child. Dental care may include, but is not limited to: dental examinations, prophylaxis (cleaning), fluoride treatments, x-rays, fillings, crowns, dental pulpotomy, spacers, extractions and/or any other treatment deemed necessary.

I______________________________________(print parent/legal guardian name) request and authorize *Fowler Dental Clinic* and its personnel to deliver dental care to my child listed below as deemed necessary in the diagnosis and/or treatment of the minor child.

Child's Name: ____ **DOB:**____________________
Allergies or Current Medications:____
____

LIMITATIONS
Identify any specific limitations on the kinds of dental services/treatment for which this authorization is given. If none, please state "NONE":____

Parent/Legal Guardian Contact Information For Questions DURING THE APPOINTMENT TIME

Parent/Legal Guardian Name:____
Contact Phone # ________________________________Alternate Phone #:_____________________________
Relationship to minor (circle one): Parent / Legal Guardian

I hereby authorize the below listed individuals to bring my child to his/her appointments if I am unable to attend. I understand that medical/dental advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice or when a minor becomes the age of 18 and that a photocopy of this form is considered valid as the original.

Name:____Relationship:____________________
Name:____Relationship:____________________
Name:____Relationship:____________________
Name:____Relationship:____________________

Print Name:____
Signature:____Date:____________________