

PARENT/GUARDIAN CONSENT TO MEDICAL, DENTAL, OR HOSPITAL CARE

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|-----------------------------|---------|----------|---------------|
| Child's Name (Last) | (First) | (Middle) | Date of Birth |
| Address | City | State | ZIP Code |
| Parent/Guardian Name (Last) | (First) | (Middle) | |
| Telephone | Cell | E-Mail | |

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child. I further agree to pay all charges for the dental, medical, or hospital care or treatment.

As parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

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| Print Name of Parent/Guardian | |
| Signature of Parent/Guardian | Date |

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