



**Oregon Health & Science University
Hospitals and Clinics
School of Dentistry**
Department of Pediatric Dentistry
611 SW Campus Drive
Portland, Oregon 97239
Phone: (503) 494-8980, Fax: (503) 418-4331

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

**OHSU PRE-DOCTORAL PEDIATRIC DENTISTRY CLINIC
PARENTAL/LEGAL GUARDIAN DESIGNATING CAREGIVER TO CONSENT FOR DENTAL
TREATMENT OF A MINOR CHILD**

Please fill out the following form and provide copies to each person responsible for caring for your child.
Please note:

- You must complete a separate form for each child and if there will be more than one person you are designating as a Caregiver.
- If all blanks are not filled out completely, or if the form is illegible, the consent will not be considered valid.
- This consent form is only valid for 90 days from the date of your signature below.

CHILD'S INFORMATION

Child's Full Name (Last, First, Middle)

Date of Birth

Home Address

Home Phone Number

City, State, Zip Code

Full Name of Parental Contact (Last, First, Middle)

Phone Number

CAREGIVER INFORMATION

Full Name of Caregiver (Last, First and Middle) *Please print*

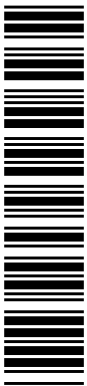
Phone Number

Relationship to Child

I hereby give the above named Caregiver authorization to consent for all routine dental treatment for the above named Child that may be required during my absence. I do **not** authorize the Caregiver to consent to any treatment involving sedation or intra-operative medication, other than local anesthetic. I agree to pay for all services provided to my child authorized by Caregiver in my absence.
(Note: Consent for treatment is not required in emergency situations.)

This authorization shall be effective until 90 days from the date of my signature below, unless earlier revoked in understand I can revoke this by sending written notice to:

OHSU School of Dentistry, Department of Pediatric Dentistry
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Patient Identification

_____ (initial) I have completed and/or read the attached medical history form and there are no changes.

OR

_____ (Initial) I have read the attached medical history form and the following has changed (please print and be thorough). Please let us know if any medication has been changed, added or discontinued.

PARENTAL/LEGAL GUARDIAN CONSENT FOR DENTAL TREATMENT OF A MINOR CHILD

By signing below, I declare that I am the parent or legal guardian of the Child named above and that I have legal authority to designate this Caregiver to give consent for my Child's dental care.

Printed name of Parent/Legal Guardian (circle one)

Date

Signature of Parent/Legal Guardian (circle one)

Date

Signature of Witness to Parent/Legal Guardian's signature
(Witness may not be caregiver listed above)

Date