CONSENT FOR AUTHORIZATION OF DENTAL TREATMENT FOR MINORS

l,		, of		County,
State of	aı	n the custodia	l parental ha	ving legal custody of
	, a min	or child, age	, born	
	I authoria	authorize		, of
	County, Sta	te of		, to do any acts
which may be necessary or probut not limited to, the power institution, or the employing of may be needed for such health including anesthesia, X-ray exaphysicians, dentists, and other life-sustaining procedures.	(1) to provid of any physic h care, and (amination, p	le for such headian, dentist, notice (2) to consent to consent of the consent of	alth care at an nurse, or othe to and author of operations,	r person whose service rize any health care, and other procedures be
This consent shall be effective writing.	from the da	ata it is execut	ed until the d	ate I terminate it in
By signing here, I indicate that importance of, to communicate document, (2) I am fully inform the full scope and importance	te, and to as ned as to th	sign the healt e contents of	h care decision	ns covered by this t, and (3) I understand
(Custodial Parent's signature)		(Date)		
STATE OF	COUNTY OF	=		
On thisday of				ne the named o me to be the person
described in and who execute he (or she) executed the same the foregoing instrument are to	and being o			
	Magazinia and an analysis and a second and a	, Nota	ry Public	
My Commission Expires:				