**AUTHORIZATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the following person(s) to make any and all decisions regarding dental treatment when I am unable to bring my child to his/her appointments:

Grandparent(s):

1)

2)

Aunt/Uncle:

1)

2)

3)

4)

Other:

1)

2)

3)

4)

I understand by signing this I am giving full authority to above mention to make any and all decisions regarding treatment for my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent or guardian