KALEIDOSCOPE KIDS DENTISTRY

NON PARENT AUTHORIZATION

I authorize_____

(name of the person bringing the patient/minor)

to escort my child_____to their dental appointments during my absence.

I approve the following treatments to be done to my child:

- ___Exam
- ___X-rays
- ___Prophy Cleaning
- ___Fluoride
- ___ Silver Diamine Fluoride
- ___Composite Resin Fillings
- ___ Stainless steel crowns/ Pulpotomy
- ___Extractions
- ___Spacer Maintainers

I request to be contacted to the phone number listed below if there is any change in treatment plan, if any other recommendations are needed during the treatment.

Phone number:_____ Date:_____

Parent/Guardian name:_____

Signature:_____