Consent for Dental Treatment of Minors in Absence of Parent/Legal Guardian

Indian Hills Community College Dental Hygiene Program
525 Grandview Ave, Ottumwa, IA 52501

I, _____, give Indian Hills Community College Dental Hygiene Clinic
Parent/Guardian

permission to treat my child, _____, while I am not physically
Child's name

present. The individual(s) bringing my child to their appointment are listed below and are at least

eighteen (18) years of age.

Accompanying adult(s): _____

Relationship to child: _____

☐ My child is of legal driving age and may be unaccompanied by an adult to dental appointments.

I give my authorization for all dental treatment, including routine procedures, that may be required during my absence: x-rays, exams, prophylaxis, preventive procedures including fluoride, and sealants, for the above-named child.

This authorization shall remain in effect until:

☐ One (1) year from date signed below

OR

☐ Until _____/_____/_____ (month, day, year)

Printed name of parent/guardian: _____

Signature: _____ Date: _____

Please return this form **prior** to child's appointment. If you have any questions, please contact the IHCC Dental Hygiene Clinic at 641-683-5209 or email us at: Dental.Clinic@indianhills.edu