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

Patient Identification

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
611 SW Campus Drive Portland, Oregon 97239
Phone: 503 494-8980 Fax: 503 418-4331

CO1400

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

Continued from page 1

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 Date
(Witness may not be caregiver listed above)