UnityPoint Health
St. Luke's Hospital

Consent to Treat Minor in Parental Absence
St. Luke's Dental Health Center

In the event you (parent/guardian) are unable to be here at the Dental Health Center, or be reached, while your child is being treated, we would like to have the name(s) of people who you have agreed can bring your child, and make decisions about their dental care. Parent or guardian should speak with those listed below who would be caring for your child in your absence.

When your child comes to the Dental Health Center without you (the parent or legal guardian), we will try to contact you to authorize his/her dental treatment. Please write your name and phone number(s):

Parent/Guardian(s):

Name 1: ____ Relationship to patient: ___________________________

Contact Numbers: 1. Phone #: _________________________ 2. Ph #: ________________ _____ 3. Ph #: ______________

Name 2: _________________________________ _______ Relationship to patient: __________________________

Contact Numbers: 1.Phone #: __________________________ 2 Ph #: ______________________ 3. Ph #:________________

If we cannot reach you, we will then talk with person(s) listed below. The person(s) listed below must be here at the DHC if you are not, and must be 21 years or older.

Authorized Person(s):

I hereby authorize the person(s) listed below to consent to my child's dental treatment while at the Dental Health Center, if I am absent.

Name: _____________________________________ Ph:_____ _______________ Relationship to child: _______________

Name: ______________________________________Ph:____ ________________ Relationship to child: _______________

This form applies to the following child:

Name: _______________________________________ DOB: ____________________

This authorization form will remain effective until otherwise changed by me in writing. I understand that it is my responsibility to update this information as needed. I may be asked to update this information with a new dated signature annually.

Signature of parent/legal guardian/person having legal custody (if signed by other than parent, please indicate name and relationship to child).

____ ________________

Signature of parent/legal guardian **Date**

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Relationship to patient

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