Children's Dentistry Of Sanford, LLP

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Release Form

As the parent/legal guardian of _____, I request that in my absence the above-named child be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and xray treatment of the above minor. I have not been given a guarantee as to the results of examination of treatment. I authorize the hospital or medical/dental facility to dispose of any specimen or tissue taken from the above named minor.

In the event that my dependent is injured or ill while under the care of the caregiver, I hereby give permission to the caregiver to provide first aid for said dependent and to take the appropriate measures, including contacting the Emergency Medical Service (EMS) system and arranging for transportation to the nearest emergency medical facility. If medical care becomes essential, I give permission to the caregiver to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the caregiver on my behalf for the benefit of my dependent, I authorize the caregiver to request, obtain, review and inspect any and all information bearing upon my dependent's health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent and that I am responsible for all charges in connection with the care and treatment rendered to my dependent during this period.

Child's Date of Birth:_____/_____/_____

Date of Last Tetanus Booster: _____/_____/_____

Known allergies of this child, including allergies to medicine:

_____
_____
_____

Any other medical problems/changes which should be noted:

_____
_____
_____

Medications:

_____

Family Physician: _____ Phone:_____

I, _____, as the parent/legal

guardian of _____, give permission for

_____ _____
Caregiver(print name of person bringing pt. to appt.) relationship to patient

to bring my child to the office of Children's Dentistry of Sanford, Dr. Mark and Megan Lucier. I am allowing the above named person to make any needed decisions that may arise during the appointment.

Signature of parent/legal guardian:_____

Date:_____

Date of Appt:_____

Please be advised that this is a ONE time release form for the above "Date of Appt" ONLY. A new form will need to be filled out for each additional appointment if a legal guardian/parent is unable to attend.