Center for
PEDIATRIC DENTAL HEALTH
EMILY EILERMAN • DMD

Center for Pediatric Dental Health
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Surrogate Form

I, ______________________________(Name of Parent or Legal Guardian), give permission to the following individual(s) listed below to accompany my child, __________________________(Child's Name) to their dental visit at the Center for Pediatric Dental Health. With this I realize the individual(s) listed below will have the authority to make all necessary treatment decisions while my child is present at their dental visit. I will be available to be reached at ________________________(phone number) if necessary during their dental visit in case of emergency.

Please note: All individual(s) listed below will need to be age 18 or older and will need to present a photo ID upon arrival at the Center for Pediatric Dental Health prior to your child being seen. This form is valid for one year.

1. ____(name of individual accompanying child)
   ____(individual's relationship to child)
2. ____(name of individual accompanying child)
   ____(individual's relationship to child)
3. ____(name of individual accompanying child)
   ____(individual's relationship to child)
4. ____(name of individual accompanying child)
   ____(individual's relationship to child)
5. ____(name of individual accompanying child)
   ____(individual's relationship to child)

_________________________________(Signature of Parent/Legal Guardian)

_________________________________(Date)