

## CONSENT FOR MINOR

I, \_\_\_\_\_, hereby give my consent for Kemper Meadow Family Dentistry to perform the routine and preventative procedures of diagnostic x-rays (to detect cavities) and/or fluoride (to prevent cavities) on my son/daughter, \_\_\_\_\_, in the event that I am not able to be with him/her at their dental appointment. I understand that this consent is applicable only when such treatment is timely and beneficial, and applies to adult children who are still financially dependent. If at any time treatment or restorative work is diagnosed and/or necessary, I will be notified before treatment is started.

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Signature of parent or guardian

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Date