AUTHORIZATION FOR DENTAL TREATMENT

        The undersigned, the parent and/or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, hereby authorizes R.E. Day, DDS; Rachel Turak, DDS; Morgan Nowery, DDS, MSD and staff to do all dental treatment, which may be required for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, on any given date in the office of Pediatric & Teenage Dentistry, 3000 Hampton Center, Suite B, Morgantown, WV 26505. I, also, give authorization for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to sign for all necessary treatment which could also include, but is not limited to, x-rays, sealants, restorative treatment, local anesthetic, nitrous oxide, sedation medications, and/or the use of restraints.

Parent/Legal Guardian                      Date

**STATE OF**

**COUNTY OF                                               TO WIT:**

          The undersigned, a Notary Public in and for the County and State aforesaid, does hereby CERTIFY that                                              , whose name is signed to the writing above, has this day sworn to and acknowledged the same before me in said County upon authority duly granted.

          Given under my hand this                    day of                                      , 20

                                      Notary Public in and for the State of

 (SEAL)