HAASDENTAL
DOVER

Release Form

As the parent/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 licenses technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures, and x-ray 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 event that my dependent is injured or ill while under the care of the caregiver, I hereby give permissions to the caregiver to provide first aid for said dependent, and to take appropriate measures, including the Emergency Medical Service (EMS) system and arrange 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.

Patient's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Please continue to fill out the information on the following pages.

Haas Dental Dover
750 Central Ave, Suite B
Dover, NH 03820
(603) 617-2882
pedo.dover@haasdentalnh.com

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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: _____

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I, _____, as the parent/legal guardian of

_____, give permission for Caregiver

_____ _____

(Print name of person bringing to appt.) (Relationship to patient)

to bring my child to the office of Haas Dental Dover. 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: _____

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