KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

PARENTAL CONSENT

To allow another person to bring your child to an appointment.

Name of child:_____

Child's DOB:_____

Ms./Mrs./Mr. Name:_____Phone#:_____ is at least eighteen years of age. I grant permission to examine, treat, administer immunizations, administer medication, provide general medical assessment and care, and dental services that may include fluoride treatment, restoration or tooth extraction to my child in my absence. I also grant this individual permission to make decisions regarding my child's treatment if necessary should an emergency arise and I am unreachable. I understand payment is expected at the time of treatment.

Start date _____

☐ Today only
☐ 1 year from today's date
☐ Other _____

Parental contact information for questions regarding treatment of child:

Parent or Legal Guardian Signature: _____

Phone: Cell:_____Home:_____Work:_____

Address:_____City:_____Zip:_____

Today's Date: _____

This signed form supersedes all previous forms effective as of Today's Date signed above

Child's information:

Allergies to drugs or foods:_____

Medications:_____

Other important medical information:_____

Office Use:
Adult Identification Confirmed: ☐ Driver's License ☐Photo ID ☐Other_____
Verbal consent given by:_____Date:_____
Employee Name:_____Date:_____
Witness by employee name:_____Date:_____

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