Lincoln-Lancaster County
Health Department

AUTHORIZED CONSENT AND APPOINTMENT OF AGENT

I authorize the attending dentist and/or hygienist of the Lincoln-Lancaster County Health Department to carry out any dental order, examine, and/or treat my child _____, in my absence in accordance with the Health Department's schedules and policies.

Further, I hereby appoint _____(adult 19 years or over), as my agent and representative for the purpose of authorizing and consenting to hospital care and/or medical care of the above named child for any reaction to medicine, illness, or injury while such person is in the care of the agency and when I am not immediately available to give such consent.

Have there been any changes in the medical and/or dental health of this child since the last dental visit? Yes_____ No_____.

Allergies_____

Family Physician_____

Physician Phone Number _____

Dated this _____ day of _____, 20_____

_____

Parent or Legal Guardian Address

_____

Phone

_____

Witness

This statement can be revoked in writing at any time and expires in any event after the school year it is signed.

Revised 08/27/2024