



***INFORMED CONSENT FOR MINOR(S)***

**DATE:** \_\_\_\_\_

***I give consent for Dr. Howell and staff to perform the necessary treatment needed on my son/daughter in my absence. I understand and accept any financial responsibility for this appointment.***

**Emergency Contact #** \_\_\_\_\_

**Print Child's Name** \_\_\_\_\_

**Print Parents Name** \_\_\_\_\_

**Parents Signature** \_\_\_\_\_