



Emergency Dental Consent

This form grants dental care in parental absence. This form must be presented upon admission for treatment.

Child's Full Legal Name _____

In the event that your child may require emergency or dental care while attending Angeli Cristiani Childcare 2200 Beaver Ave Des Moines Iowa 50310. Every effort will be made to notify the parent/guardians first. However in the event you are out of the city or unable to be reached the center requires the following information to be provided.

In the event my child _____

Requires emergency/dental care, I hereby give my consent for medical treatment to

Hospital _____

Dentist _____

His/her designee to provide this care I agree to pay all the costs and fees contingent on any emergency dental care or treatment for my child as secured or authorized under this consent.

Name of Parent/Legal Guardian _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Doctor _____ Dr. Phone _____

Doctor Address _____

Hospital Preference _____

Emergency Contacts _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of last Tetanus _____ Religious Preference _____

Insurance # _____ Name _____

Fathers Signature _____ Date _____ Social security # _____

Mothers Signature _____ Date _____ Social Security # _____

If you don't name a dentist all dental Emergencies will be handled by Fluer Denristy Dr. Carol Cleaver

