



Dr. James P. Muir

Authorization for Emergency Treatment of Minor Child

Name of Child/Minor

James P. Muir D.D.S., Citrus Park Dental

Name of Physician

As the parent/guardian of the above-named child/minor, I hereby give permission to the physician named above to treat the child/minor in the event that a medical emergency arises and I am unable to personally consent to the treatment. I also agree to be responsible to the physician for charges for medical services rendered.

Signature of parent or guardian

Date

Printed name of parent or guardian