



Temporary Delegation of Guardian/Parental Rights
And Limited Power of Attorney for Consent to Provide Treatment

Patient Information: (Print Legibly - Black Ink)

First Name Last Name Date of Birth: ___/___/___ Male or Female

Street Address City State and Zip Code

Home Phone Number Emergency Phone Number

Known Allergies/Drug Sensitivities:

Known Medical Conditions:

Any Limitations to Delegation:

I/We are the parent(s) or legal guardian(s) of the above name patient. I/We appoint (in order of appearance):

Name: Phone:

Address: DL or State ID#:

Name: Phone:

Address: DL or State ID#:

To act on my/our behalf to consent to dental treatment for the above-named patient during period(s) of my/our absence from ___/___/___ through ___/___/___ I understand this delegation includes receiving health information about the patient necessary to make health care decisions.

IN NO EVENT IS THIS DELEGATION OF TEMPORARY RIGHTS EFFECTIVE FOR MORE THAN SIX (6) MONTHS FROM THE SIGNATURE DATE BELOW. THIS FORM DOES NOT DELEGATE POWER TO CONSENT TO MARRIAGE OR ADOPTION.

This Delegation of Powers is given under MCLA Section 700.5103. I/We have signed and delivered this document on the date(s) listed below. At least one parent or legal guardian must sign this form below. The signature(s) should be witnessed by a person who is not an employee or contractor of Grand Haven Smiles and is not related by blood or marriage to the family OR by a Notary Public.

Option 1

Parent/Guardian: Signature Witness Signature
Printed Name

Parent/Guardian: Signature Witness Signature
Printed Name

Option 2

On this day before me, the undersigned Notary Public the parent (s)/ guardians (s) herein named personally appeared and freely executed this document. He/she/they () is /are personally known to me or () has /have provided satisfactory evidence of their identity.

Notary Public: Signature Date