



**Parent Permission Form**

In the event you are unable to bring your child/children for an appointment, SEMO Health Network requires your permission for another adult to bring your child in to our clinics for Medical/Dental treatment.

**Please list any adult that has permission to bring your child in:**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Father's Name:** \_\_\_\_\_

**Legal Guardian** (if different from parents) \_\_\_\_\_

1. \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_
2. \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_
3. \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_
4. \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_
5. \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_

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**Parent Signature**

**Date**

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**SEMOHN Staff**

**Date**

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**Witness**

**Date**

***Please keep in mind that only the persons listed above will be allowed to sign for your child.***