Power of attorney

(only valid together with a copy of the identity card)

Patient (child):

_____ _____ _____

Last Name First Name Date of birth

_____

Address

Parent or guardian:

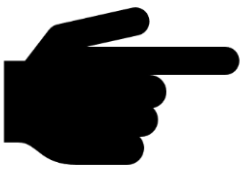
_____ _____ _____

Last Name First Name Date of birth

_____

Address

I hereby authorize Mrs./Mr.



_____

(Last name, first name, date of birth)

_____

(Address)

for the above-mentioned child, for whom we have joint custody, the appointment for the

Dental treatment under anesthesia

on: _____

in sole responsibility and to give all medically necessary measures / declarations as well as the consent to anesthesia also in my name.

If I have any questions about anesthesia, I have the opportunity to inform myself at any time by calling 09602/615353.

_____ _____

Date Signature of legal guardians