

CONSENT FOR MEDICAL TREATMENT

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO
 _____ TO PROVIDE ALL EMERGENCY DENTAL OR
FACILITY NAME
 MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST
 (D.D.S.) FOR

_____, THIS CARE MAY BE GIVEN UNDER WHATEVER
NAME
 CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDENT.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE PARENT/AGENCY REPRESENTATIVE/GUARDIAN SIGNATURE

HOME ADDRESS

HOME PHONE
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WORK PHONE
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