CONSENT FOR MEDICAL TREATMENT-
Adult and Elderly Residential Facilities

AS THE CLIENT, AUTHORIZED REPRESENTATIVE OR CONSERVATOR, 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**

FOR _____ THIS CARE MAY BE GIVEN UNDER WHATEVER
NAME

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE INDIVIDUAL NAMED ABOVE.

CLIENT HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ _____
DATE | CLIENT/AUTHORIZED REPRESENTATIVE/CONSERVATOR SIGNATURE (CIRCLE APPROPRIATE TITLE)

HOME ADDRESS

HOME PHONE	WORK PHONE