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	WORK PHONE