CONSENT FOR EMERGENCY MEDICAL TREATMENT-Children's Residential Facilities

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

NAME

____. THIS CARE MAY BE GIVEN UNDER WHATEVER

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED

ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

FACILITY NAME

HOME ADDRESS	
HOME PHONE	WORK PHONE
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LIC 627B (9/08) (CONFIDENTIAL)	