CONSENT FOR EMERGENCY MEDICAL TREATMENT-Adult and Elderly Residential Facilities

NAME

AS THE CLIENT, AUTHORIZED REPRESENTATIVE OR CONSERVATOR, 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

_____ . THIS CARE MAY BE GIVEN UNDER WHATEVER

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

CLIENT HAS THE FOLLOWING MEDICATION ALLERGIES:

FACILITY NAME

DATE	CLIENT/AUTHORIZED REPRESENTATIVE/CONSERVATOR SIGNATURE (CIRCLE APPROPRIATE TITLE)
OME ADDRESS	
OME PHONE	WORK PHONE

LIC 627C (ENG/SP) (4/00) (CONFIDENTIAL)