CONSENT FOR EMERGENCY MEDICAL TREATMENT-Adult and Elderly Residential Facilities

AS THE CLIENT, AU	THORIZED REPRESENTATIVE	R CONSERVATOR, I HEREBY GIVE CO	NSENT TO
	FACILITY NAME	PROVIDE ALL EMERGENCY MEDICAL	OR DENTAL CARE
PRESCRIBED BY A	DULY LICENSED PHYSICIAN (N	D.) OSTEOPATH (D.O.) OR DENTIST (D	D.D.S.) FOR
	NAME	THIS CARE MAY BE GIVEN	UNDER WHATEVER
CONDITIONS ARE N ABOVE.	NECESSARY TO PRESERVE TH	LIFE, LIMB OR WELL BEING OF THE I	NDIVIDUAL NAMED
CLIENT HAS THE FOLLOWIN	G MEDICATION ALLERGIES:		
	DATE	CLIENT/AUTHORIZED REPRESENTATIVE/CO (CIRCLE APPROPRIATE T	
HOME ADDRESS			
HOME PHONE		VORK PHONE	
()		()	

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