

# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Adult and Elderly Residential Facilities

AS THE CLIENT, AUTHORIZED REPRESENTATIVE OR CONSERVATOR, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE  
FACILITY NAME

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 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

( )