Consent for Medical and/or Emergency Treatment**

I_____, of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions by medical doctors, hospitals, or they are authorized designees, as may, in their professional judgment, be necessary to provide for the medical surgical emergency care of my

_____ _____
(relationship) *(hereafter "dependent")-Full Name*

I further give my consent to _____
(hereafter "caregiver")-Full Name

Who will be caring for my dependent for the period _____through _____, to arrange for routine or emergency medical and or dental care and treatment necessary to preserve the health of my dependent. In the event that my dependent is injured or ill while under the care of the caregiver, I hereby give permission to the caregiver to provide first aid for said dependent and to take the appropriate measures, including contacting the emergency medical services (EMS) system. And arranging for transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my dependent, I direct that caregiver attempt to contact me. However, if medical care becomes essential, I give permission to the caregiver to make such decisions regarding such treatment as deemed appropriate for the medical doctor or hospital or their authorized designee. in furtherance of any treatment decisions to be made by the caregiver on my behalf for the benefit of my dependent, I authorized the caregiver to request, obtain, review and inspect any and all information bearing upon my dependents health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my dependent during this.

Parent/Legal Guardian Full Name: _____

Home Address: _____ Phone: _____

Primary Care Physician: _____Address: _____

Health Insurance Carrier: _____

Health Insurance Policy # and Group #_____

Dentist_____ Address_____

Allergies _____ Side Effects_____

Signature of Parent/Legal Guardian_____Date_____

Witness Name_____ Signature_____Date_____