

**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

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WORK PHONE

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