CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Adult and Elderly Residential Facilities

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

Elite Elder Care
FACILITY NAME

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

_____
NAME

. 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:

DATE

CLIENT/AUTHORIZED REPRESENTATIVE/CONSERVATOR SIGNATURE
(CIRCLE APPROPRIATE TITLE)

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )