## 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 PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR  THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE INDIVIDUAL NAMED ABOVE.		
CLIEN	ENT HAS THE FOLLOWING MEDICATION ALLERGIES:		
	DATE	CLIENT/AUTHORIZED REPRESENTATIVE/CONSERVATOR SIGNATURE (CIRCLE APPROPRIATE TITLE)	
HOME AD	ADDRESS		
HOME PH	PHONE WORK	PHONE	
(	)	)	

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