CONSENT FOR MEDICAL TREATMENT

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO

Kids First Learning Center

FACILITY NAME

TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL 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 WHATEVI CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDENT.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT/AGENCY REPRESENTATIVE/GUARDIAN SIGNATURE

HOME ADDRESS

HOME PHONE

( )

WORK PHONE

( )

DC 627 (12/02) (CONFIDENTIAL)