

# CONSENT FOR MEDICAL TREATMENT

---

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO  
Montessori House of Children 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  
 \_\_\_\_\_ THIS CARE MAY BE GIVEN UNDER WHATEVER  
 NAME  
 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

LIC. 627 (12-92) (CONFIDENTIAL)

LIC 627.doc

cfd 9-12-99