_____ _____
Name Date

Card Signer's Business Phone Number_____

Dependent's Allergies: 1._____ 2._____
3._____

Dependent's past medical problems:_____
_____

Date of last tetanus shot:_____

Dependent's physician:_____
Or_____

Compliments of Fairchild Medical Center, Yreka, California

_____ _____ _____
Name Date of Birth Age

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I, as legal parent or guardian, do hereby give my consent for _____ to receive all medical care prescribed by a duly licensed physician.

This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of my dependent.

Date:_____ Signed:_____

Home Address:_____

_____

FMC-124 Home Phone#:_____