_____ _____ _____

Name Date of Birth Age

CONSENT FOR MEDICAL TREATMENT OR A MINOR

I, as legal 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 _____

_____

Home Phone # _____

FMC-124

Name _____ Date _____

Card Signer's Business Phone Number _____

Dependent's Allergies: 1. 2.

3.

Depdendent's past medical problems _____

_____

Date of last tetanus shot _____

Dependent's physician _____

or _____

Compliments of Fairchild Medical Center, Yreka, California