CAREGIVER CONSENT FORM FOR MEDICAL TREATMENT

I ____, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by medical doctors, hospitals or their authorized designees, as my in their professional judgement be

______________________________ (relationship)

____. (hereafter “dependent”) – Full Name.

I futher give my consent to ____.
(hereafter “caregiver”) – Full Name

Who will be caring for my dependent for the period _________________ through _________________, to arrange for routine or emergency medical and/or dental care and treatment necesarry to preserve the health of my dependent. In the event that my dependent is injured or i while under the care of the caregiver, I hereby give permission to the Emergency Medical Service (EMS) system and arranging for transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my dependent, I direct that the caregiver attempt to contact me. However, if medical care becomes essential, I give permission to the caregiver to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the caregiver on my behalf for the benefit of my dependent's health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent and that I am responsible for all reasonable changes in connection with the care and treatment rendered to my dependent during this period.

____
Date

____ Signature of Legal Guardian	____ Dentist
____ Witness	____ Address
____ Name	____
____ Address	____ Phone

____

____
Name of dependent

____ Phone	____ Allergies
____ health Insurance Center	____
____ Health Insurance Policy # and Group #	____
____ Personal Care Physician	____ Date of last tetanus booster
____ Address	____ Medications dependent is taking
____	____