



CONSENT FOR MEDICAL TREATMENT

I/We hereby agree to the performance of such treatment, anesthetics, operations and/or medications deemed necessary in the opinion of the attending physician on the applicant named below.

Full Printed Name _____

In an emergency, contact _____ **Relationship** _____

Emergency Contact Phone () _____ **Emergency Contact Phone** () _____

Emergency Contact Email _____

Emergency Contact Email _____

Applicant's Signature *(as in the passport or photo i.d.)*

If Applicant is under 18 _____

Parent/Guardian Full Printed Name _____

Relationship to Applicant _____

Parent/Guardian Signature _____

Date _____

Signature of Notary Public

Seal of Notary Public