Fort Hope, Inc.

Consent for Medical Treatment

Name of Minor:_____ Date of Birth: _____

Name of Parent/Guardian:_____

Address: _____

Phone (H):_____ Phone (W): _____

Medical conditions: _____
Medications:_____
Allergies: _____

In case of emergency contact:

1) _____
Name Phone Relative

2) _____
Name Phone Relative

Medical Doctor: _____ Phone: _____

As the parent, agency representative or legal guardian of the above named minor, I hereby give consent to Fort Hope, it's agents & representatives to provide all emergency medical or dental care prescribed by a duly licensed physician (MD) or dentist (DDS) should the need arise. This care may be given under whatever conditions are necessary to preserve life, limb or well-being of said minor.

By my signature below, I hereby certify that I am the parent, foster parent, or legal guardian of the above named minor and that I am acting in that capacity. Further, I acknowledge that I have read this document and understand its content.

_____

Signature of parent/guardian Date