Fort Hope, Inc.

PO Box 132, Arroyo Grande, CA 93421

805-473-1805

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.

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Signature of **ALL** parent•/guardian•Á^•ãåã * Á ãc@Ác@ Á&@ãåÁ Date

Revised: September 29, 2010