

# CONSENT FOR MEDICAL TREATMENT

---

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO  
ME'RAJ ACADEMY TO PROVIDE ALL EMERGENCY DENTAL OR  
**FACILITY NAME**

MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR  
DENTIST (D.D.S.) FOR:

\_\_\_\_\_. THIS CARE MAY BE GIVEN UNDER WHATEVER  
**CHILD NAME**

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDENT.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**PARENT/AGENCY REPRESENTATIVE/GUARDIAN SIGNATURE**

HOME ADOFEZS

HOME PHONE

WORK PHONE: