CONSENT FOR MEDICAL TREATMENT

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO

CNBA RESIDENTIAL CARE HOME
FACILITY NAME
TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

TROY QUIROZ
NAME
THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDENT.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

01-16-2012
DATE

PARENT/AGENCY REPRESENTATIVE/GUARDIAN SIGNATURE

HOME ADDRESS
393 E. SAN FERNANDO STREET, SAN JOSE, CA. 95112

HOME PHONE	WORK PHONE
408-271-9244	N/A