HSDC
Hearing, Speech & Deaf Center

MEDICAL INFORMATION AND CONSENT FOR MEDICAL TREATMENT

MEDICAL INFORMATION

Client Name:_____
Address: _____
Emergency Phone:_____
Primary Care Provider:_____
Health Insurance:_____
Medications:_____
Allergies:_____
Other Relevant Medical Information: _____
_____
_____

CONSENT FOR MEDICAL TREATMENT

I hereby appoint the staff of HSDC to act on my behalf in authorizing or providing emergency treatment to include: first aid and CPR; contacting 9-1-1; diagnostic procedures; medical, surgical, and hospital care; or treatment procedures to be performed for myself or my child by a licensed physician, hospital, or emergency personnel when deemed necessary and advisable by the physician to safeguard my or my child's health. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment. I also give permission to be transported by ambulance or aid car to an emergency center for treatment. I do not hold Hearing, Speech & Deafness Center responsible for any emergency treatment that may be administered. I acknowledge that I am responsible for all charges in connection with care and treatment. This consent is effective for the duration of my or my child's therapy program.

Client Name: _____

Parent/Guardian Name (if client is under the age of 18): _____

Signature: _____ Date: _____