IDENTIFICATION AND EMERGENCY INFORMATION

PHYSICIAN TO BE CALLED IN EMERGENCY:

Name: _____

Address: _____

Phone Number: _____

If physician cannot be reached, what action should be taken?

Emergency Room _____

Other:_____

_____

_____

CONSENT FOR MEDICAL TREATMENT

AS THE PARENT, AGENCY REPRESENTAION OR LEGAL GUARDIAN OF _____, I HEREBY GIVE CONSENT TO **TIBON GOJU RYU** TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OR DENTIST (D.D.S.) FOR MY CHILD/DEPENDANT. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB AND/OR WELL BEING OF MY CHILD/ DEPENDANT.

DATE: _____

PARENT/GUARDIAN: _____

HOME ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____