CONSENT TO TREAT FOR
EMERGENCY MEDICAL, SURGICAL and DENTAL

_____	_____	_____
NAME OF CHILD	**DOB**	**DATE**

TO WHOM IT MAY CONCERN:

I hereby authorize, give consent, and assume financial responsibility for any dental services, medical or surgical care, eye care, or routine tests to be performed on my child while he/she is at the Caliente Youth Center, Caliente, Nevada, or when said services are deemed necessary or advisable by the attending physician. I also consent to the administration of whatever anesthetics are advisable or necessary. I further consent to have my child's medical history report sent to the Infirmary at the Caliente Youth Center or to any treatment facility which is addressing the emergency medical needs of my child.

MEDICAL/DENTAL INSURANCE INFORMATION

Complete the following information and enclose a copy of front and back of insurance card and/or signed insurance form.

Insured's Name on Policy:

_____

Insurance Company Name:

_____

Insurance Company Address:

_____

Policy Number: _____ Group Number: _____

Insurance Claims or Contact telephone number: _____

Other Insurance (attach separate sheet): _____

Insured's Social Security Number: _____

Insured's Date of Birth: _____

Parent/Guardian Email: _____

Parent/Guardian Telephone number: _____

Parent/Guardian Home Address: _____

Parent/Guardian (please print): _____

_____ _____

Parent/Guardian signature Date