

## 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 18): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_