Medical Treatment Consent Form

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Emergency Contact: _____

Phone Number: _____

Consent for Emergency Medical Treatment

I, the undersigned, hereby give my consent for emergency medical treatment to be administered to the above-named patient in the event that I cannot be reached or am unable to provide consent due to my condition.

I understand that this treatment may include but is not limited to:

- Assessment by medical personnel
- Administration of medications
- Diagnostic tests
- Surgical procedures

I acknowledge that while I understand the nature of the proposed treatment, I also recognize that there are inherent risks involved in any medical procedure.

Signature of Patient or Guardian: _____

Date: _____

If signed by Guardian, relationship to Patient: _____