First Care
HEALTH CENTER

Date of Care:_____

We/I, _____ for _____

☐ Mother ☐ Father ☐ Legal Guardian ☐ Dependent ☐ Son ☐ Daughter

whose date of birth is _____, hereby voluntarily consent to the rendering of such care, including diagnostic, laboratory, and medical treatment by authorized members of the First Care Health Rural Health Clinic staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered.

Signature:_____ Date:_____

Mother, Father or Legal Guardian

In case of emergency, I can be reached at:_____

Telephone consent (only if parent unable to sign consent)

Telephone consent:_____ Date:_____ Time:_____

Witness # 1_____ Witness # 2_____

Witness only needed in the case of telephone consent