Consent for Treatment

I ____ do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary. Further, I understand that all efforts will be made to contact my family prior to treatment. In the event, my family cannot be reached in an emergency; I give permission to the group leader to make the decisions necessary for treatment. I further understand that the doctors, dentists, and other providers attending to me will take all reasonable safety precautions during their care.

Further, I agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is give to me. Any policy of the association sponsoring this event will be used as the secondary coverage.

Signature: ____

Printed Name: ____

Date: ____

Witness: ____

Witness Printed Name: ____

Date: ____