**Marshfield Area Respite Care Center, Inc.**
**MARCC**
211 S. Maple Ave.
Marshfield, Wisconsin 54449
715/384-8478

## CONSENT FOR TREATMENT

NAME OF PARTICIPANT_____

I _____, as representative for the above named participant in the Marshfield Adult Respite Care Center, authorize Dr._____, or his/her designee, to treat any condition requiring emergency treatment or acute care at Marshfield Clinic Health System. If admission is required, I further authorize that also. This consent shall remain in full force until my arrival at the Hospital or the Clinic.

_____ _____
Representative's Signature Relationship

_____ _____
MARCC Representative's Signature/Title Date