ST. PAUL'S LUTHERAN SCHOOL MEDICAL CONSENT FORM 2016/17

Please contact the office if there are any changes to this information.

(Name and grade of child(ren)

First/Last Name and Grade	*First/Last Name and Grade*
First/Last Name and Grade	*First/Last Name and Grade*
First/Last Name and Grade	*First/Last Name and Grade*

Child(ren's) Home Address: _____
Street *city/state/zip code*

Primary Phone (*This number will be called first in case of an emergency*): _____

FATHER/GUARDIAN	MOTHER/GUARDIAN
Cell Phone: _____	Cell Phone: _____
Employer: _____	Employer: _____
Work Phone: _____	***Work Phone:*** _____

Whom shall we notify in case we are unable to reach either mother, father, or legal guardian?

Name	*Phone Number*	*Relationship*

DOCTOR'S NAME	**MEDICAL INSURANCE CARRIER**
DOCTOR'S PHONE NUMBER	**MEMBER'S NAME**
	INDENTIFICATION NUMBER

MEDICAL HISTORY: *(list child and condition)*

Allergies/Medication: _____

Treatment: _____

Chronic or existing diseases, or medical problems and treatment/medication: *(e.g. diabetes, epilepsy)*

_____

_____

- ***Please note, a School Medication/Authorization Form needs to be filled out by parents and (or) physician for all medications brought or administered by delegated personnel.***

Date of last Tetanus injection: _____
(list child and date of last injection)

(CONTINUED ON BACK SIDE)

ST. PAUL'S LUTHERAN SCHOOL MEDICAL CONSENT FORM

Dear Parent of Legal Guardian:

Occasionally when children become seriously ill or injured we find it difficult to locate the parents or legal guardians. In your absence or when you cannot be reached, we need this completed consent form to obtain proper medical attention for your child, should it be needed in an emergency. We request your cooperation in filling out this report.

I (We) _____ **and** _____
(PARENT/GUARDIAN) (PARENT/GUARDIAN)

Do hereby state that I am, (we are) the parent(s) of

_____**, born** _____
(Name of child) **(Month, day, year)**

_____**, born** _____
(Name of child) **(Month, day, year)**

_____**, born** _____
(Name of child) **(Month, day, year)**

_____**, born** _____
(Name of child) **(Month, day, year)**

I (We) authorize the pastors, teachers, and advisors, who represent St. Paul's Lutheran School of Onalaska, WI, to consent to any necessary examination, anesthetic, medical diagnosis, surgery, or treatment and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advise of any physician or surgeon licensed to practice medicine in the state of Wisconsin or Minnesota. This consent shall be valid for the activities of St. Paul's Lutheran School during the 2016-2017 school year.

_____ _____
SIGNATURE OF PARENT/GUARDIAN **SIGNATURE OF PARENT/GUARDIAN**

_____ _____
Date *Date*

PLEASE LIST BELOW ANY ADDITIONAL INFORMATION: