

Consent for Medical Treatment

I hereby give consent for a representative of Rejoice Lutheran Church to authorize emergency medical treatment, surgery or dental care for my child if deemed advisable or necessary by an emergency medical professional or attending physician.

Date: _____

Name of Student

Parent Signature

Parent Name (printed)

Emergency Information

Please provide the information below in case of emergency:

Emergency Contact

Home phone

Cell phone

Relationship to Student

Student's Primary Physician

Office phone

Family's Insurance Company

Policy #

Please list any medical/physical conditions we should be aware of, including (but not limited to): allergies, physical limitations, pre-existing conditions, recent surgeries or illnesses, any medications currently used or other special concerns/comments

