

# Consent for Medical Treatment

As the parent, or legal guardian, I hereby give consent to Reformation Lutheran Church and School to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.), Osteopath (D.O.), or dentist (D.D.S.) for

\_\_\_\_\_ (Name of Student)

This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent.

My child has the following medication allergies: \_\_\_\_\_

My child has the following other allergies: \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian Signature

\_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code

\_\_\_\_\_ Home phone with area code \_\_\_\_\_ Work phone with area code

\_\_\_\_\_ MOM cell phone with area code \_\_\_\_\_ DAD cell phone with area code

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As parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the emergency dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

I (We), as legal guardian(s) of the above-mentioned student, do hereby and herewith give and grant permission to my child to participate in the special school activities, field trips, and athletic events. I further agree to hold and save harmless the Board of Education, Principal, teachers and congregation of Reformation Lutheran Church and School, 4670 Mt. Abernathy Ave., San Diego, California, 92117 from all suits, claims, or demands of every kind and character arising out of or in connection with the said special school activity in which my child shall take part and participate.

\_\_\_\_\_ Signature of Parent(s) or Legal Guardian(s) \_\_\_\_\_ Print Name \_\_\_\_\_ Date