

BETHANY LUTHERAN SCHOOL

CONSENT FOR MEDICAL TREATMENT

As the parent, agency representative or legal guardian, I hereby give consent to **Bethany Lutheran** to seek for the provision of any/all emergency dental or medical care prescribed by a duly licensed physician (M.D.), Osteopath (D.O.) or Dentist (D.D.S.) for my child _____. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

_____ Date _____ Parent/Agency Representative/Guardian Signature

_____ Home Address

_____ Home phone () Work phone () Cell phone ()

PLEASE LIST ALL KNOWN ALLERGIES (Medication, Food, Environmental, etc.):

PLEASE DESCRIBE IN DETAIL TREATMENT SHOULD STUDENT HAVE AN ALERGIC REACTION OR REQUIRE MEDICAL ATTENTION (i.e. epi-pen, inhaler, etc.)

