

## CONSENT FOR MEDICAL TREATMENT

As the parent, agency representative or legal guardian, I hereby give consent to Our Savior's Lutheran 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 : \_\_\_\_\_ (child's name)

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

My child has the following Medication/Food Allergies or Health Issues:

---

I authorize administration of Tylenol or Jr. Tylenol to my child on an as needed basis e.g. (headache, earache, sore throat):

Parent Signature

I authorize administration of Benadryl to my child on an as needed basis e.g. (allergic reaction):

Parent Signature

Physician's Name: \_\_\_\_\_ Phone# \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_

Father's Signature \_\_\_\_\_  
Date: \_\_\_\_\_

Mother's signature \_\_\_\_\_

Home Address \_\_\_\_\_

Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

---

## CONSENT FOR MEDICAL TREATMENT

As the parent, agency representative or legal guardian, I hereby give consent to Our Savior's Lutheran 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 : \_\_\_\_\_ (child's name)

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

My child has the following Medication/Food Allergies or Health Issues:

---

I authorize administration of Tylenol or Jr. Tylenol to my child on an as needed basis e.g. (headache, earache, sore throat):

Parent Signature

I authorize administration of Benadryl to my child on an as needed basis e.g. (allergic reaction):

Parent Signature

Physician's Name: \_\_\_\_\_ Phone# \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_

Father's Signature \_\_\_\_\_  
Date: \_\_\_\_\_

Mother's signature \_\_\_\_\_

Home Address \_\_\_\_\_

Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_