LUTHER HIGH SCHOOL

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Last

First

In your absence, we need this completed consent form to obtain proper medical attention for your child, should it be needed.

Student Name ___________________________________ DOB: ___________

I (We) authorize **any staff person or adult who represents Luther High School**, Onalaska, Wisconsin, 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 and special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state of Wisconsin. ***This consent is valid for all high school activities while your child is enrolled in Luther High School.***

_____________________________	_____________________________
(Signature of Parent/Guardian)	*(Signature of Parent/Guardian)*
_____________________________	_____________________________
(Date)	*(Date)*

Home phone _____________________

Work phone _____________________
(Father)

Home phone _____________________

Work phone _____________________
(Mother)

Grades: 9th___ 10th ___ 11th ___ 12th ___

Preferred Provider: Gundersen/Mayo
(circle one)

_____________________________	_____________________________
(Doctor's Name)	*(Member's Name)*
_____________________________	_____________________________
(Benefit Code)	*(Account Number)*

Medical History: Allergies, if any, including medication:
____
____

Chronic or existing diseases or medical problems: (e.g. diabetes, epilepsy): ___________
____
____

Medicines your child is now taking: ____
____

Any other pertinent information: ____
____
____

A copy of THIS FORM IS CARRIED by STAFF and COACHES TO ALL EVENTS.