

**LUTHER HIGH SCHOOL – 2018-19 School Year
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 _____ Grade _____ 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 the FISCAL CALENDAR YEAR of July 1,2018 to June 30,2019 for all high school activities.***

(Signature of Parent/Guardian)

(Signature of Parent/Guardian)

(Date)

(Date)

Home phone _____

Work phone _____
(Father)

Insurance ID Number _____

Home phone _____

Work phone _____
(Mother)

(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): _____

Date of last tetanus injection: _____

Medicines your child is now taking: _____

Any other pertinent information: _____

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