Emergency Consent

Faith Lutheran School/Childcare

"Raising up families and followers of Jesus Christ"

Date _____ School Year _____

Limited Power of Attorney for Emergency Medical Care Authorization

Student's Name _____
Last First M.I.

TO WHOM IT MAY CONCERN:
I hereby give permission for my child to be given emergency treatment by a qualified staff member at Faith Lutheran Church, School, and Child Care Center. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. In the event that I cannot be contacted or the situation is life threatening, I further consent to the medical, surgical, and hospital care treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safe guard my child's health.

Parent's Signature _____ Date _____

Medical Information

	Physician's Name	Office Phone #	Name of Insurance Company	Group and/or Policy #
Physician				
Dentist				
Preferred Hospital				

Allergies/health issues: _____

_____

_____

Current medications: _____

_____

Emergency Contacts (please list in the order you would like them to be contacted)

Name	Relationship to Student	Phone #

The undersigned accepts all financial responsibility for any and all care/services rendered and indemnifies Faith Lutheran School therefrom. Further, the undersigned releases Faith Lutheran School from any and all liability arising out of any act or omission hereunder.

Parent's Signature _____ Date _____