TRINITY LUTHERAN SCHOOL
Medical Permission Slip
School Year _____

Student's Name _____ Home Phone # _____

Parent's contact information:

Mother Cell # _____ Mother Work # _____

Father Cell # _____ Father Work # _____

Emergency phone # (different than above)

Name _____ Phone # _____

Name _____ Phone # _____

Physician Name _____ Phone # _____

The undersigned parent or guardian of (child's name) _____ authorizes any Trinity Lutheran, Stewardson staff member to obtain medical care for him/her in the event such care is necessary during the school year. If possible, the parent(s) or guardian of the name individual will be contacted in the event of an emergency. Permission is hereby granted to the licensed physician or accredited hospital and their associates to perform any medical and/or surgical procedures that are deemed essential to treatment of the above named individuals.

Signed _____ Date _____

Brief Medical History

Allergies _____

Other medical conditions and/or medications: _____

_____

_____

Any other pertinent information, i.e., special diet requirements?

_____

COPY OF INSURANCE CARD (Needed by first day of school)