MUST BE TURNED IN ON THE FIRST DAY OF SCHOOL

TRINITY LUTHERAN SCHOOL
Medical Permission Slip
For the school year 20__-20__

Student's Name: _____ Home phone number: _____

Parent's work phone number & cell phone number

Mother:_____ _____

Father:_____ _____

Emergency phone numbers (different than above):

Name Phone number

1.) _____

2.) _____

Physician's name and phone number:

_____

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 this school year. If possible, the parent(s) or guardian of the named individual will be contacted in the event of an emergency. Permission is hereby granted to the licensed physician of accredited hospital and their associates to perform any medical and/or surgical procedures that are deemed essential to the treatment of the above named individual.

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)