AUTHORIZATION FOR MEDICAL TREATMENT

Lutheran Church of the Resurrection

Child's Name (Last)	(First)	(Middle)	Date of Birth
Address	City	State	Zip Code

Name of Parent or Guardian		
Home Phone	Work Phone	Cell Phone
Name of other emergency contact		Relationship
Home Phone	Work Phone	Cell Phone

Medical/Health Plan ____ Policy Number ________________

Physician's Name ____ Phone Number ________________

Dental Plan ____Policy Number ________________

Dentist's Name ____ Phone Number ________________

Medical Conditions ____

Allergies/Allergic reactions ____

Current Medications ____

I, the undersigned parent/guardian of ________________________________, consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed necessary and advisable by any physician and/or surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child. I further agree to pay all charges for the dental, medical, or hospital care or treatment. I will not hold the Lutheran Church of the Resurrection or its officers, agents, servants, or employees responsible for any injury that may occur to my child.

Parent/Guardian printed name ____

Parent/Guardian signature ____ Date __________