Lutheran Vanguard of Wisconsin
Emergency Medical Information & Medical Treatment Consent Form

General Information – Please Print!

Student Name: ____ Birthdate:____/_____/_____
(Last Name) (First Name)

Parent(s) Names: ____

____

Address: ____

City: ____ State: _________ Zip: _____________

Primary Contact Phone (Home or Cell): (________) - ___________________________

Father's Work Phone: (_______) - ___________________________

Mother's Work Phone:(_______) - ___________________________

Family Doctor: ____

Office Phone: (_______) - _________________________________

Home Phone: (_______) - _________________________________

Student's Doctor (if different): ____

Office Phone: (_______) - _________________________________

Home Phone: (_______) - _________________________________

Health Insurance Company: ______________________________ Policy #: ___________________

Name of Principal Insured: ____

Name of Emergency Contact Person: ____

Relationship to student: ___________________________________

Work Phone: (_______) - ___________________________________

Home Phone:(_______) - ___________________________________

(Please fill out the information on the other side of this page also)

Specific Personal Information – Please Print!

Please list any significant health problems of which the chaperones should be aware:

___

___

Does the student have any allergies (include any drug-related allergies)?

___

___

Please list all medications (+ dosage) the student is taking now, or will be taking this summer, if known:

___

___

Please list the date of the student's last tetanus shot: ____________________________________

Medical Treatment Consent

1. Permission is hereby granted for the nurses and/or chaperones who accompany Lutheran Vanguard of Wisconsin to administer non-prescription medication for the relief of minor discomfort, and/or to administer approved emergency and first aid care as necessary.

   Signature of Parent/Guardian: ____

   Date: ________/________/________

2. I hereby authorize medical treatment, administration of anesthesia, and surgical treatment(s) for my child, ______________________________, in the event a medical situation occurs and the hospital or physician(s) are unable to contact me. This authorization extends to any hospital and to physician and nursing personnel within the hospital, as well as to any physician where treatment is rendered in the physician's office. I release from medical responsibility and liability the hospital, medical authorities, and the physician's acting on the authority of this medical treatment consent form to give any care which is deemed necessary for my child.

   Signature of Parent/Guardian: ____

   Date: ________/_______/________

Please return this form to LVW on or
before the February rehearsal (Feb 1-2)
LVW - 5300 N Meade St - Appleton, WI 54913