

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: _____

Home Phone: (_____) - _____

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 first rehearsal (January 14-15)
LVW-5300 N Meade St-Appleton, WI 54913*