



MEDICAL TREATMENT CONSENT FORM

I hereby give permission for any and all medical attention necessary to be administered to my child in the event of an accident, injury, sickness, etc., under the direction of the persons listed below until such time as I may be contacted. My child's name is:

This release is effective for the time during which my child is participating in the athletic program for the 2010 - 2011 athletic season at Peace Lutheran School, including traveling to and/or from competition. I also hereby assume the responsibility for payment of any such treatment.

Parents'/Guardians' Names: _____

Home Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Company: _____

Policy Number: _____

Family Physician: _____

Physician Address: _____
Street City State Zip Code

Physician Phone: _____

My child's known allergies and reactions:

In case I cannot be reached, either of the following people is designated (name and phone number):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Signature of Parent or Guardian

Date

This form will accompany your child to all athletic events at Peace and other schools.