

**CONSENT FOR EMERGENCY MEDICAL TREATMENT –
Child Care Centers Or Family Child Care Homes**

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

BETHEL LUTHERAN SCHOOL TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULLY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.)

FOR _____ . THIS CARE MAY BE GIVEN UNDER WHATEVER
NAME

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL BEING OF THE CHILD
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ DATE

_____ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE

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WORK PHONE

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