ZOAR LUTHERAN PRESCHOOL

190 S.W. 3rd Ave.
Canby, OR 97013
503-266-4061

Consent for Medical Treatment

Complete this Consent for Medical Treatment form. This form authorizes treatment for your child in your absence.

Child's Full Name: ____________________________________ Age: ________________

I hereby authorize the Zoar Lutheran Preschool staff, who is eighteen years of age or older, to seek any medical or surgical treatment of the above child that such staff deems advisable if a parent or legal guardian cannot be reasonably located when my child is taken for treatment at any hospital or clinic.

The above authorization will be effective as of __________ and will expire after _________.

During this period, the parent/legal guardian of the above child can be contacted at:
Name:__________________ Phone (h)______________(w)______________(c)________________
Name:__________________ Phone (h)______________(w)______________(c)________________

Health Insurance Company:____
Group Number: ________________________________ Policy Number:_____________________
Name of Primary Insured:____
Employer: _____________________________________ Phone: _____________________________
Child's Physician: _____________________________ Phone: ______________________________
Chronic Illnesses or Allergies: ____
Current Medications: ____

Signed: _______________________________________ Date: ________________________________
Parent/Legal Guardian

Zoar Lutheran Preschool does not discriminate on the basis of race, color, national origin, or ethnic origin.