

ZOAR LUTHERAN PRESCHOOL

190 SW 3rd Avenue

Canby, OR 97013

503-651-3723

AUTHORIZATION FOR CONSENT OF TREATMENT OF CHILD

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 have the consent of any medical or surgical treatment of the above child that such staff deems advisable if a parent or legal guardian cannot reasonably be located when my child is taken for treatment at any hospital/clinic.

The above authorization will be effective as of _____ and will expire after:
_____ (Total period may not exceed six months.)

During this period, the parents/legal guardian of the above child can be contacted at the following location(s):

1) _____ Phone: _____

2) _____ Phone: _____

Health Insurance Company: _____ Phone: _____

Group Number: _____ Policy Number: _____

Name of primary Insured: _____

Employer: _____ Phone: _____

Family Physician: _____ Phone: _____

Chronic Illnesses or Allergies: _____

Current Medications: _____

Signed: _____ Date: _____

Parent's/Legal Guardian's Signature

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