

Our Savior's Lutheran School Consent/Release & Medication Treatment

Name _____

Address _____ City _____

ST _____ Zip _____

Birthdate ___/___/___

Parent's/Legal Guardian's

Name: _____

Home Phone (____) _____ Work Phone (____) _____

Dr.'s Name: _____

Ph #: _____

Please do not send your child/youth to school if they have a fever or illness.

Allergies: _____

Medications: _____

(If medicine is to be given at school, please pick up required forms from the office)

I give my permission for the office staff to give the over-the-counter medications I have circled in accordance with standard label directions: Tylenol Benadryl

As the parent, agency representative or legal guardian, I hereby give consent to Our Savior's Lutheran School to provide all emergency dental or medical care prescribed by a duly Licensed Physician (M.D.), Osteopath (D.O.) or Dentist (D.D.S.)

for : _____ (child's name)

This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my child.

Parent Signature Date

Print Name