Our Saviour's Lutheran Church
Medical Release and Consent Form

Child's Name:
D.O.B.
Address:
City:
Father's Name:
Employer:
Home Phone:
Work Phone:
Mother's Name:
Employer:
Home Phone:
Work Phone:
If Parents are not available, in an emergency contact
Name:
Phone:
Address:
City:
Relationship to child:
Child's/Family Doctor & phone:
Child is Allergic To:
Medical Information (as pertains to church activities)

Insurance Company:
Policy #:

This form will be presented to the attending physician if your child is in need of medical treatment during your absence. This will prevent delay of treatment for your child due to lack of proper authorization. Individual hospitals may require additional authorization.

Parent/Guardian name:
"I hereby authorize the treatment, administration of anesthesia,
and surgical treatment for my child
in the event of a medical situation occurring
during my absence or when the hospital or physicians is unable to contact me. This authorization extends to any hospital or physician's office and both physician and nursing personnel within the hospital or physicians' office as well as any physician where treatment is rendered in the hospital or physician's office, medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary to my minor child."

Signature of Parent or Guardian:
Date:
Witness:

I do/do not give permission for Our Saviour's to photograph or video tape my child for promotional purposes.

Parents/Guardians are responsible for updating information as the need arises otherwise Our Saviours, its employees, and members will presume everything is correct and current.