TRINITY LUTHERAN CHURCH&SCHOOL

Rev. Stephen Henderson, Senior Pastor
Rev. David Kipp, Associate Pastor
Rev. Daniel Gadbaw, Associate Pastor
Karol Ketcher, Director of Music
Christine Miller, Principal
Susan Magruder, Business Manager
Katie Gutierrez, Director of Technology

Medical Permission Form
Used for Field Trips and Standard Medical Treatment

Basic Information

(Please print)

Name: _____ Grade: _____ Gender: _____
Last First Middle

Address: _____
Street City State Zip

Date of Birth: _____ Home Phone: _____

Father/Guardian Name: _____ Cell: _____ Work: _____

Mother/Guardian Name: _____ Cell: _____ Work: _____

Alt. Emergency Contact: _____ Cell: _____ Home: _____

Student's School: Trinity Lutheran School
250 S. Indiana Ave
Crown Point, IN 46307

School Secretary: Lisa Ann Cizmar
School Phone: 219-663-1578 ext. 3, 2
School Fax: 425-663-1586

Brief Medical History

Special Health Condition (list) Medication and Dosage (if taken)

1. _____
2. _____
3. _____

Additional related information: _____

Should student be restricted from any type of activity? No Yes, Explain: _____

Is student allergic to any medication? No Yes, List: _____

Authorization for Treatment

I, the parent or legal guardian of (child) _____, authorize _____ to obtain medical care for my child in the event such care is necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment for such care.

I release Trinity Lutheran School, Crown Point, IN, its employees and agents, from any damages, liability, or loss resulting from their securing in good faith medical care for my child.

Parent/Guardian Signature: _____ Date: _____

Insurance Information

Medical Insurance Company Name: _____ State: _____

Policy Number: _____ Name on Card: _____

Physician's Name: _____ Phone: _____

Authorization for Non-Prescription Drugs

I, the parent/guardian of _____ request, authorize, and give written permission to Trinity Lutheran School and its representative to administer the medication below in accordance with the instructions provided.

Medication: _____ Dosage: _____ Frequency: _____

For symptoms of: _____

Parent/Guardian Signature: _____ Date: _____

Authorization for Prescription Drugs

(to be filled out by physician)

This is to inform you that _____, a student enrolled in your school, is currently under my medical care for: _____.

As a part of that care, this student must receive the following medication and/or treatment:

Medication: _____ Dosage: _____

Frequency: _____For the symptoms of: _____

I request and authorize you to administer this medication and/or treatment in accordance with the above instructions. These instructions remain in force until _____, or until you are otherwise notified by me. Problems concerning these prescriptions can be referred to me.

_____

Physician Signature Physician Phone

250 S. Indiana Avenue • Crown Point, IN 46307-4174
Phone: 219-663-1578 • Fax: 425-663-1586
info@trinitycp.org • www.trinitycp.org