Medical Permission Form
Trinity Lutheran School, 250 South Indiana Avenue, Crown Point, Indiana

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
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)

Date: _____

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

_____

Physician Address (Street, City, State, Zip)