Fox Valley Lutheran High School
Student Medical Consent Form

	Graduation Year
	Last Name

Instructions

1. Complete this form by supplying requested information.
2. Mail or return completed form to: FOX VALLEY LUTHERAN HIGH SCHOOL
   ATTN: Medical Records
   5300 N. Meade St.
   Appleton, WI 54913

Family Information

Student Name	Last -	First -	Middle -
	Birth Date -		HS Grad Year -
Father's Information	Father's Name -		
	Address -		
	City -	State -	Zip Code -
	Employer		
Telephone	Home - ( )	Cell - ( )	Work - ( )
Mother's Information	Mother's Name		
	Address -		
	City -	State -	Zip Code -
	Employer		
Telephone	Home - ( )	Cell - ( )	Work - ( )

Medical Information

Student's Doctor	Name -	
	Office Phone - ( )	Home Phone - ( )
Insurance Company	Name -	
	Policy Number -	
	Policy Holder's Social Security Number -	

List special current medical conditions affecting this student
(daily medications, last Tetanus shot, current doctor's instructions, etc)

Student is Allergic to	

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

Parent/Guardian Signature ______________________________ Date______________

Witness Signature ______________________________ Date______________

Rev. 06-2010