Authorization to Treat A Minor and Emergency Contact Information

In case of a medical emergency I (we), the undersigned parents or legal guardians of _____ a minor, do herby authorize the doctors on duty as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical, or any surgical diagnosis or treatment and any hospital care which is deemed advisable by, and is rendered under the general supervision of any physician or surgeon licensed under the provisions of the medical practice act, whether such diagnosis is rendered at the office of said physician or at a hospital. In case of such a medical emergency, it is understood that Illinois Lutheran Schools will use the best efforts possible to contact the undersigned to obtain advance parental consent.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforesaid physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provision of the Civil Code of Illinois.

_____ _____ _____

Child's Birth Date Signature(s) of Parent/Guardian Date

In case of a medical emergency please contact:

Name _____ Relationship to Child _____

Home Phone _____ Work Phone _____ Cell Phone _____

Name _____ Relationship to Child _____

Home Phone _____ Work Phone _____ Cell Phone _____

Allergies and Sensitivities

a. Penicillin or other antibiotics	Y	N	_____
b. Morphine, Codeine, Demerol or other narcotics	Y	N	_____
c. Novocaine or other anesthetics	Y	N	_____
d. Aspirin, emperin or other pain remedies	Y	N	_____
e. Sulfa drugs	Y	N	_____
f. Tetanus antitoxin or other serums	Y	N	_____
g. Adhesive tape	Y	N	_____
h. Iodine or merthiolate	Y	N	_____
i. Any other drug or medication	Y	N	_____
j. Any foods, such as eggs, milk, chocolate	Y	N	_____
k. Bee stings or other insect stings / bites	Y	N	_____

Drugs Taken Recently

a. Cortisone	Y	N	_____
b. ACTH	Y	N	_____
c. Anticoagulants	Y	N	_____
d. Tranquilizers	Y	N	_____
e. Hypotensives	Y	N	_____

f. Other: _____

Has the patient ever received treatment for Asthma, Rheumatism, or Rheumatic Fever? Y N _____

Other medical information: _____

Family Physician _____ Phone Number _____

Insurance Company _____ Policy / Group # _____