CONSENT FOR MEDICAL TREATMENT

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AS THE PARENT, AGENCY REPRESENTATIVE, OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO **ST. LOUIS OF FRANCE SCHOOL** TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OR DENTIST (D.D.S.) FOR _____. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDENT.

_____

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ _____

Date Parent/Agency Representative/Guardian Signature

_____

Home Address

_____

Home Phone ( ) Work Phone ( )

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