

Mt. Calvary-Grace Lutheran School

1614 Park Avenue • La Crosse, WI 54601-5796

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2022-2023 School Year

Permission to Treat

To be presented to the Emergency Department

Full Legal Name (First, Middle, Last) _____

Date of Birth _____ Grade this school year _____

I give my permission to treat my minor son or daughter (or legal guardian) named above for any emergency medical problem or injury that may be incurred while my son or daughter is under the care of Mt. Calvary-Grace Lutheran School. ***This permission extends through May 25, 2023.***

I understand that I will be contacted by the Hospital and/or Physician as soon as possible before or after emergency treatment, and the medical illness or injury will be explained to me, and any treatment necessary will be explained to me.

Facility: Gundersen Health System MayoClinic Child's Clinic # _____

Child's Physician _____

Significant medical problems _____

Current medications _____

Known allergies _____

Name of insurance company _____

Policy # _____

Home phone number _____

FATHER: Work phone number _____ Cell phone: _____

MOTHER: Work phone number _____ Cell phone: _____

Parent/Guardian Signature _____ **Date:** _____