The Lutheran High School of Kansas City

Insurance and Emergency

GENERAL INFORMATION

Student's Name _____

Parents' Name _____

EMERGENCY PHONE NUMBER(S):

Mother's Work (_____)_____ Father's Work (_____)_____

Emergency contact if parents are unavailable _____

Best number to reach: (_____)_____

Family Physician's Name _____ Phone Number (_____)_____

CONFIRMATION OF INSURANCE

I do hereby certify that our family medical insurance plan provides adequate coverage for the above named student and will remain in effect throughout the school year.

Name of Insurance Company _____

Group Number _____ Member ID Number _____

_____ _____/_____/_____

Signature of Parent or Guardian Date

AUTHORIZATION OR CONSENT TO TREATMENT OF A MINOR

(We must have your permission to place your student under the supervision of proper medical personnel in the event of an emergency, should no parent or guardian be accessible.)

I/We, the undersigned, parent(s) of _____, a minor, do hereby authorize Lutheran High School – Kansas City, Missouri as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. 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 aforementioned physician in the exercise of his best judgment may deem advisable.

Date _____ Father/Guardian _____

Mother/Guardian _____