

**DALLAS LUTHERAN SCHOOL  
EMERGENCY MEDICAL RELEASE FORM  
2007 - 2008 SCHOOL YEAR**

Student's Name: \_\_\_\_\_ Entering Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**CONSENT**

As the parent/legal guardian of \_\_\_\_\_, I request that in the event that reasonable attempts to contact us at (phone #'s) \_\_\_\_\_ or \_\_\_\_\_ have been unsuccessful, I hereby give my consent for:

- a. The administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (physician) at \_\_\_\_\_ (phone #) or Dr. \_\_\_\_\_ (dentist) at \_\_\_\_\_ (phone #), or in the event the designated practitioner is not available, by another licensed physician or dentist.
  
- b. In the event it is deemed necessary, my hospital of choice is \_\_\_\_\_ or the nearest hospital.

I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures (major surgery requires the medical opinions of two (2) other licensed physicians or dentists concurring in the necessity for such surgery prior to the performance of such surgery), and x-ray treatment of the above named minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named students. Facts concerning the student's medical history including allergies, medications taken, and any physical impairments to which a physician should be alerted are:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**REFUSAL TO CONSENT**

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date