CONSENT FOR MINOR MEDICAL TREATMENT

Minor Patient Name: _____ Date of Birth: _____

Minor Patient Social Security Number: _____ Parent Contact Number: _____

Parent Name: _____ If International Send Bills to:
Parent Name:_____

Parent Address: _____
c/o Lustre Christian High School
4 Lustre High Cir
Lustre, MT 59225

_____

RESPONSIBLE PARTY INFORMATION FOR BILLING

Insurance Company: _____ Policy Number: _____

**A copy of the insurance card should be attached to this form.*

Policy Holder Name: _____

**If different than Parent information above*

Address for Billing: _____ Contact Number: _____

_____

Please list any relevant medical information for the Minor Patient, such as asthma, allergies, diabetes, heart conditions, or other medical conditions. Also please list all medications the minor is currently taking.

_____

_____

AUTHORIZATION

I, _____, do hereby give permission to LCHS Representive ,
Parent or Legal Guardian *Person Entrusted with Child's Care*

to seek and obtain the care indicated below for my child, _____,
Name of Child

during my absence if I cannot be promptly reached at the above contact number. I also give consent for the above named person/persons to sign any necessary forms or permits. I understand my insurance policy listed above will be billed and I will be responsible for any amount not covered by insurance. I understand this is required to prevent any undue delay and assure prompt treatment for my child.

- ☑ Any Medical Treatment
- ☑ Sport Physicals
- ☑ Emergency Services
- ☑ Urgent - Cold/Flu

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Printed Name of Parent or Legal Guardian Relationship to Minor