

## 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: c/o Lustre Christian High School
	4 Lustre High Cir Lustre, MT 59225
RESPONSIBLE PARTY INF	FORMATION FOR BILLING
nsurance Company:	Policy Number:
*A copy of the insurance card should be attached to this form.	
Policy Holder Name:	
*If different than Parent information above	Contact Number:
Address for Billing:	Contact Number.
Please list any relevant medical information for the Minor Patient, some medical conditions. Also please list all medications the minor is curr	
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AUTHOR	RIZATION
I. do hereby give	e permission to LCHS Representive .
I,, do hereby give	e permission to LCHS Representive ,  Person Entrusted with Child's Care
Parent or Legal Guardian	Person Entrusted with Child's Care
Parent or Legal Guardian  to seek and obtain the care indicated below for my child,	Person Entrusted with Child's Care  Name of Child
Parent or Legal Guardian	Person Entrusted with Child's Care  Name of Child  ve contact number. I also give consent for the above 5. I understand my insurance policy listed above will be
to seek and obtain the care indicated below for my child,  during my absence if I cannot be promptly reached at the above named person/persons to sign any necessary forms or permits billed and I will be responsible for any amount not covered by	Person Entrusted with Child's Care  Name of Child  ve contact number. I also give consent for the above 5. I understand my insurance policy listed above will be
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