
Child's name

DOB

In the event my child needs medical treatment and I cannot be reached or emergency treatment is needed, I give permission to Saint Martin's Lutheran School Staff to secure medical treatment for my child_____.

Parent's signature

Date

Child's name

DOB

In the event my child needs medical treatment and I cannot be reached or emergency treatment is needed, I give permission to Saint Martin's Lutheran School Staff to secure medical treatment for my child_____.

Parent's signature

Date