

St. Luke's Day School & Kindergarten
11080 Knights Road
Philadelphia, PA 19154

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

In the event of an emergency requiring a physician's care, do you wish us to call your family physician?
___ No ___ Yes, please provide the following information

Physician Name _____ Phone # _____

Address _____

I (We), _____ and _____, do hereby state
that I am aware (we are) the parent(s) r legal guardian(s) of _____
a minor age _____ born on _____, who resides with me (us) at _____
_____.

I (we) _____ and _____ authorize for
emergency purposes only, a designated employee of the center transport the above named minor by
ambulance and consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment,
and/or hospital care to be rendered to the minor under the general supervision and the advise of any
physician or surgeon to practice medicine in the state of _____.

Last tetanus/diphtheria booster _____

Allergies to drugs or foods _____

Please list any special medications or other pertinent information _____
_____.

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

_____ and _____ have appeared before me on this
date _____ and I have witnessed their signatures.

Notary Public

My commission expires: _____