Emergency Medical Authorization
Faith Lutheran Preschool

The undersigned hereby authorizes Faith Lutheran Preschool as my agent to give consent to surgical or medical treatment by any licensed physician or hospital in the state of Washington for my child when such treatment is deemed necessary by such physician and I cannot be reached within a reasonable length of time by reason of absence from the community or otherwise.

Such consent may include but is not limited to administration of necessary anesthetics, medical treatment, tests, x-ray, examination, transfusions, injections or drugs, and the performing of whatever operation may be deemed necessary or advisable. It is understood this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required for the 2017-2018 school year.

_____ _____

Date Parent/Guardian Signature

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Child's **Full** Name