



PLEASE TYPE OR PRINT

**AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT**

If my child \_\_\_\_\_, date of birth \_\_\_\_\_,  
month/day/year

becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or Health Provider to give the emergency medical treatment required:

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

OR:

Health Provider: \_\_\_\_\_ Telephone No: \_\_\_\_\_  
M.D./N.P. (Area Code)

Address: \_\_\_\_\_

I give permission to \_\_\_\_\_, located at  
Name of Facility or Caretaker

\_\_\_\_\_ to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Coverage: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ State:  DC  MD  VA

Child's Known Allergies or Health Conditions: Yes  No   
(If yes, explain here: \_\_\_\_\_)

Home Address: \_\_\_\_\_  
Street City/State Zip Code

Area Code/Telephone No: \_\_\_\_\_  
Home Business Pager/Cell Phone

Signature: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Date: \_\_\_\_\_  
month/day/year

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