Information Updated ______

# Authorization For Emergency Treatment

**CHILD'S NAME ______________________ ______________________ ________________ Sex: M F**
**(Please Print) (Last) (First) Child's Date of Birth**

**Child's Allergies (if any): ___________________________________________**

**Child's Dr.: _________________________ Phone # ____________________**

**Family Dr.: __________________________ Phone #____________________**

**Medicines Child is Taking: ________________________________ Last Tetanus Shot: _________________**

**Outstanding Medical History (ex. Diabetes, Heart Disease, etc.): ___________________________________**

**_____________________________________________________________________________**

**Home Address:_____________________________________________Home Phone #___________________**

**Parent/Legal Guardian 1._________________________ Parent/Legal Guardian 2.______________________**

**Home Phone #________________________________ Home Phone #_____________________________**

**Place of business/Position______________________ Place of business/Position______________________**

**Business Phone#____________________________ Business Phone#_____________________________**

**Cell Phone #________________________________ Cell Phone #_______________________________**

**Pager #___________________________________ Pager #___________________________________**

**Insurance Information:**

**Insurance Company: ____________________________________________________**

**Identification/Policy No.: ____________________________________________**

**Subscriber's Name: ____________________________________________________**

**Fairfax Hospital Association**

**AUTHORIZATION FOR EMERGENCY TREATMENT**

**I, ______________________________, hereby authorize any physician member of the Department of**
**(Parent or Legal Guardian)**
**Emergency Medicine of Fairfax Hospital, and/or any member of the Medical Staff of the above mentioned hospital requested by the Department of Emergency Medicine physician, to render medical treatment, which in his judgment may be deemed necessary in the care of ______________________.**
**(Name of child or dependent)**

**All parents and legal guardians are responsible for keeping the information on this consent form current as it can not be maintained by Carousel Child Development Center or the hospital.**

**Signature: ________________________________**
**(Parent/Legal Guardian)**

**Signature: ________________________________**
**(Parent/Legal Guardian)**

Signature:________________________________
(Notary Public)
Signed before me this _________ day of ___________ in

the year 2___________.

In the city/county of ________________/_______________

in the Commonwealth State of______________________.

My commission expires:______________________________.