2016 Summer Program

INOVA HEALTH SYSTEM
AUTHORIZATION FOR EMERGENCY TREATMENT

I, _____ hereby authorize any physician or member of the Department
(parent or guardian)
of Emergency Medicine of Inova Health system and/or any member of the Medical Staffs of the above mentioned hospitals requested by the Department of Emergency Medicine physician, to render medical treatment, which in his\her judgment may be deemed necessary in the care of_____.
(Name of child)

Parent/Guardian Phone No._____Parent/Guardian Cell Phone_____

Emergency Contact _____Emergency Contact Phone_____

Child's Allergies (if any) _____

Child's Dr. _____Telephone No. _____

Family Dr._____ Telephone No. _____

Medicines Child is Taking_____

Last Tetanus Shot _____

Outstanding Medical History (ex. Diabetes, Heart Disease, etc.) _____

_____

Insurance Information:

Insurance Company_____

Identification/Policy No. _____

Subscriber's Name _____Telephone No. _____

Subscriber's Place of Employment _____

All parents and guardians are responsible for maintaining this consent form as it cannot be maintained by the hospitals.

_____ _____

(Signature) (Date)