



## AUTHORIZATION FOR EMERGENCY TREATMENT

I \_\_\_\_\_, hereby authorize any physician member of the Department of Emergency Medicine of Commonwealth Hospital, The INOVA Fairfax Hospital, ACCES, The Virginia Hospital Center and/or any member of The Medical Staff of the above mentioned hospitals requested by the Department of Emergency Medicine physician, to render medical treatment, which in his judgment may be deemed necessary in the care of \_\_\_\_\_.

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.)

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### **Insurance Information**

Insurance Company \_\_\_\_\_

Identification/Policy # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber's place of employment \_\_\_\_\_

Subscriber phone # \_\_\_\_\_

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**Parent Signature**

**Date**

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