South Riding Montessori Center

AUTHORIZATION FOR EMERGENCY TREATMENT

I, _______________________, hereby authorize any physician members of the Loudoun Hospital Center, The Fairfax Hospital, ACCESS, Fair Oaks Hospital, Reston Hospital Center 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 her/his judgment may be deemed necessary in the care of __________________________________.

Child's Allergies (if any): ____
Child's Doctor: ____________________________ Phone Number:__________________
Family Doctor: ____________________________ Phone Number:__________________
Medicines Child is Taking: ____
Last Tetanus Shot: ____
Outstanding Medical History (ex. heart disease, diabetes, etc.)______________________
____
____

INSURANCE INFORMATION:

Insurance Company: ____
Identification/Police No. ____
Subscriber's Name: ____
Subscriber's Place of Employment: ____
Subscriber's Telephone No.: Home ________________ Business ___________________

____ ________________________________
Parent/Guardian Signature Date

STATE OF VIRGINIA
CITY/COUNTY OF: _______________________________

The above was signed before me this ________ day of _________________, 20___, by

________________________________.

____
(Notary Signature)

Commission Expires: ___________________