Inova Health System
Fairfax Hospital

Authorization for Emergency Treatment

I, _____, (parent or guardian) hereby authorize any physician member of the Department of Emergency Medicine of Fair Oaks Hospital, Fairfax Hospital, ACCESS of Fairfax, ACCESS of Reston/Herndon and Mount Vernon Hospital 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)

Child's Date of Birth: _____

Child's Allergies (if any): _____

Child's doctor: _____ Telephone: _____

Family doctor: _____ Telephone: _____

Medicines child is taking: _____

Last Tetanus shot: _____

Outstanding medical history (ex. Diabetes, Heart Disease, etc.):

_____

Insurance Information

Insurance Company: _____

Identification/Policy number: _____

Subscriber's Name: _____

Subscriber's place of employment: _____

Subscriber's telephone number: _____

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

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**