GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child, ____

born ______________________________ becomes ill or involved in an accident and
Month Day Year

I can not be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: ______________________________

Address: ______________________________

or

Physician: ______________________________

Address: ______________________________

I give St. John's Episcopal Preschool 3240 O Street NW, Washington DC 20007
Facility Address

permission to take my child for this treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: ______________________________

Policy Number: ____________________ Coverage: ____________________

Medicaid Number: ____________________

Child's Known Allergies or Physical Conditions: ______________________________

____

____
Date

Signature: ______________________________

Address: ______________________________

Telephone Numbers: ______________________________
Home Cell

____
Work