INOVA FAIRFAX HOSPITAL ASSOCIATION

AUTHORIZATION FOR EMERGENCY TREATMENT

I, ___________________________________, hereby authorize any physician member
(parent or guardian)
of the Department of Emergency Medicine of Inova Hospital Association or Dewitt Army Hospital 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 is his judgment may be deemed necessary in the care of

_______________________________.
(name of child or dependent)

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

____

Subscriber's Place of Employment

____

Subscriber's Telephone No.

____