Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child _____, born on _____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____ M.D. Telephone No: _____ (Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caretaker

_____, to take my child for 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: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ☐ DC ☐ MD ☐ VA

Child's Known Allergies or Physical Conditions: _____

_____

Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____ Home _____ Business _____ Pager/Cell Phone

Date: _____ Month/Day/Year Date Updated: _____ Month/Day/Year