INOVA HEALTH SYSTEM
AUTHORIZATION FOR EMERGENCY TREATMENT

I, _____, hereby authorize any physician member of the
(parent or guardian)
Department of Emergency Medicine of the INOVA Health System and/or any member of the Medical Staffs of its 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 _____.
(child or dependent)

Child's date of birth:_____

Child's allergies (if any):_____

Child's doctor:_____ Doctor's phone_____

Family doctor:_____ Doctor's phone_____

Medicines child is taking:_____

Last tetanus shot:_____

Outstanding medical history (ex., diabetes, heart disease, etc.):_____

_____

_____

INSURANCE INFORMATION:

Insurance company:_____

Identification/Policy #:_____

Subscriber's name:_____

Subscriber's place of employment:_____

Subscriber's phone number:_____

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

_____ _____

(Date) (Signature of Parent of Guardian)