INOVA HOSPITAL ASSOCIATION
AUTHORIZATION FOR EMERGENCY TREATMENT

I,_____________________, hereby authorize any physician member of
Parent or Guardian
the Department of Emergency Medicine of Fairfax Hospital, Commonwealth Hospital, Fair Oaks Hospital, or Reston Hospital and/or 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 judgment may be deemed necessary in the care of

____________________________________.
Name of child

Child's Allergies (if any):____

Child's Doctor:___________________Phone Number:___________________

Family Doctor:___________________Phone Number:___________________

Medicine Child is taking:____

Last Tetanus Shot:___________________

Outstanding Medical History (ex. Diabetes, Heart Condition, etc.)

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INSURANCE INFORMATION:

Insurance Company_______________________________________

Identification/Policy No._____________________________________

Subscriber's Name:________________________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 hospitals.