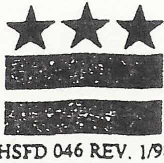

HSFD 046 REV. 1/98

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
LICENSING REGULATION ADMINISTRATION

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child ______________________, born ______________, 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 ST. ALBAN'S EARLY CHILDHOOD CENTER, INC., located at
Name of Facility or Caretaker

3001 WISCONSIN AVE., NW. WDC 20016 ______________, 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

Date: ______________