C&RCFD 046 REV 07/04

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

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child _____, date of birth _____ (month/day/year),
becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or Health Provider to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Health Provider: _____ (M.D./N.P.) Telephone No: _____ (Area Code)

Address: _____

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

_____, 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 Health Conditions: Yes ☐ No ☐
(If yes, explain here: _____

_____

_____

Home Address: _____
Street City/State Zip Code

Area Code/Telephone No: _____ (Home) _____ (Business) _____ (Pager/Cell Phone)

Signature: _____

Relationship to Child: _____

Date: _____
month/day/year

PLEASE RETAIN A COPY FOR YOUR RECORDS