



DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION

***DIVISION OF EARLY LEARNING
Licensing and Compliance Unit***

**AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
(Update Annually)**

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 Caregiver
_____, 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: _____

Parent/Guardian Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____
Home Business Cell Phone

Date: _____
Month/Day/Year

Date Updated: _____
Month/Day/Year

Place in child's folder/record.