Emergency Contact Information

Child's Name: _____ DOB: _____

Address: _____

Mother's Name: _____

Home: _____ Cell: _____ Work: _____
Email Address: _____
Address (if different from child): _____

Father's Name: _____
Home: _____ Cell: _____ Work: _____
Email Address: _____
Address (if different from child): _____

2 Alternate (non-parent) Local Emergency Contacts (ALL INFORMATION REQUIRED)

Contact #1:

Name: _____
Address: _____
Phone: _____

Contact #2:

Name: _____
Address: _____
Phone: _____

1850 Town Center Parkway Reston, VA 20190 (703) 689-9000

RESTON HOSPITAL CENTER
AUTHORIZATION FOR EMERGENCY TREATMENT

I, ________________________________, hereby authorize any physician member of the
(parent or guardian)
Emergency Department of Reston Hospital Center or any member of the Medical Staff of the hospital requested by the Emergency Department physician, to render medical treatment, which in his/her judgment may be deemed necessary in the care of
____. Date of Birth ___________________
(name of child or dependent)

Child's Allergies (if any): ____

Child's Dr.: __________________________________ Telephone #: ___________________

Family Dr.: __________________________________ Telephone #: ___________________

Medicine (s) Child is Taking: ____

Outstanding Medical History (ex: Diabetes, Heart Disease, Asthma, etc.): ___________
____
____

Insurance Information:

Insurance Company: ____

Identification/Policy #: ____

Subscriber's Name: ______________________________ Telephone # _________________

Subscriber's Place of Employment: ____

Parents and Guardians are responsible for maintaining this consent form.

_______________ ___________________________________
Date **Signature of Parent or Guardian**

- -

Please list any specific **FOOD ALLERGIES** or **DIETARY RESTRICTIONS**:

_______________________ _________________________ _______________________

_______________________ _________________________ _______________________

(Two-sided Form)