

# 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 Local Emergency Contacts (ALL INFORMATION REQUIRED)

### Contact #1:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### Contact #2:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_



**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 # \_\_\_\_\_

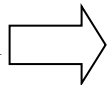
Subscriber's Place of Employment: \_\_\_\_\_

Parents and Guardians are responsible for maintaining this consent form.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent or Guardian**

Complete back of form



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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_