2024-2025

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: _____

TWO-SIDED FORM!! BE SURE TO FILL OUT THE OTHER SIDE OF THE PAGE!!

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**

Complete back of form

- -

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

_____ _____ _____

_____ _____ _____