

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: _____



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**:
