



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

PHONE: (202) 727-1839-FAX: (202) 741-5304

MAILING ADDRESS: 810 FIRST STREET, NE-4th FLOOR-WASHINGTON DC 20002

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

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 _____, to take my child for treatment.

Name of Facility or Caretaker

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: _____

Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____
Home Business Pager/Cell Phone

Date: _____ Date Updated: _____
Month/Day/Year Month/Day/Year

NOTE: Place on file in child's folder/record