A Child's Place

3100 Prosperity Ave. Fairfax, Virginia 22031

Child Emergency Medical Authorization

CHILD'S NAME:	Birthday:
Home Address:	
Home Number:	E-mail:

MOTHER'S NAME:	
Place of Work:	
Work Number:	Cell Number:
Work E-mail	
FATHER'S NAME:	
Place of Work:	
Work Number:	Cell Number:
Work E-mail:	

EMERGENCY CONTACT # 1 NAME:	
Address:	
Telephone Number:	E-mail:
EMERGENCY CONTACT # 2 NAME:	
Address:	
Telephone Number:	E-mail

The Parent (s) / Guardian authorizes **A CHILD'S PLACE**, to obtain immediate medical care and consents to hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and / or the administration of drugs to his / her child or ward if an emergency occurs when he or she can not be located immediately. It is also understood that this agreement covers only those situations that are true emergencies and only when he/she can not be reached. Otherwise, he/she expects to be notified immediately.

1. I/We will be responsible for payment of medical care expenses _____
2. Medical treatment costs covered by:
   - A. Blue Cross/Blue Shield Policy Number: _____
   - B. Medical Coverage Insurance: _____
   - C. Other Medical Insurance Company: _____
   - Policy Number: _____
3. No Insurance: _____

Child's Physician or Clinic Attending: _____
Child's Allergies (if any): _____
Actions to be taken in an emergency: _____
Child's Doctor: _____
Family Doctor: _____
Medicine Child is taking: _____
Last Tetanus Shot (Date): _____
Outstanding Medical History (ex. Diabetes ..)
_____

Date: _____ _____

(signature of Parent(s) / Guardian)

THIS INFORMATION IS TO BE KEPT BY A CHILD'S PLACE AND IS TO BE TAKEN TO THE DOCTOR AT THE TREATMENT FACILITY IN CASE OF AN EMERGENCY