EMERGENCY CONTACT AND TREATMENT AUTHORIZATION

GREAT FALLS UNITED METHODIST PRESCHOOL
10100 Georgetown Pike
Great Falls, Virginia 22066
703-759-2432

Child's Name ______________________________ Home Phone ________________
Birth Date _____________________ Child's SS# _____________________________
Mother's Name _________________ Father's Name ____________________________
Bus./Cell Phone _________________ Bus./Cell Phone__________________________

Names of friends or relatives to call, if you cannot be reached:
1. __________________________ Phone ______________ or ____________________
2. __________________________ Phone ______________ or ____________________

Physician to be called in an emergency:
__________________________________ Phone ______________________________

Dentist to be called in an emergency:
__________________________________ Phone ______________________________

Allergies: ____
Medicines Child is Taking: ____

Last Tetanus Shot: ____

Outstanding Medical History (example: Diabetes, Heart Disease, etc.): ___________
____

Health Insurance Information:
Insurance Company: ____
Identification/Policy No.: ____
Subscriber's Name: ____
Subscriber's Place of Employment: ____
Subscriber's Telephone No.: ____
I, _________________________ (parent or guardian), hereby authorize any physician member of the Department of Emergency Medicine of any area local hospital or any member of the Medical Staffs of the hospital requested by the Department of Emergency Medicine physician, to render medical treatment, which in his/her judgment may be deemed necessary in the care of ____________________ (name of child). Any expenses will be borne by the child's family.

Date _______________ Signature of Parent or Guardian ______________________