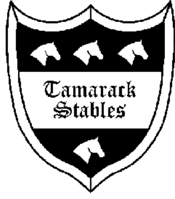

Rivers Edge

Authorization for Emergency Treatment

I, ____, hereby authorize any physician member of the department of Emergency Medicine of Mary Washington Hospital, and/or member of the Medical Staff of the above mentioned hospital requested by the Department of Emergency Medicine physician to render medical treatment, which in his judgment may be deemed necessary in the care of (name of child/dependent: ____.

Child's allergies (if any):____

Child's physician:____________________________________ Telephone:_______________________

Family physician:____________________________________ Telephone: _______________________

Medicines child is taking: ____

Last tetanus shot: ____

Outstanding medical history (ex. diabetes, heart disease, etc.): ___________________________________

____

____

INSURANCE INFORMATION:

Insurance Company: ____

Identification/Policy No.: ____

Subscriber's name:____ Tel: _______________________

Subscriber's place of employment: ____

All parents and guardians are responsible for maintaining this consent form as it cannot be maintained by the hospitals.

CALL IN EMERGENCY:

____ Tel: ___________________________
Name/Relationship to camper

____ Tel: ___________________________
Name/Relationship to camper

____ Tel: ___________________________
Name/Relationship to camper

____ Tel: ___________________________
Name/Relationship to camper

Auth. Signature:____ **Date:** _________________________