A Child's Place @ Hollin Hall

1500 Shenandoah Road, Alexandria, Virginia 22308
(703) 765-8811 FAX (703) 765-6356

Child's Emergency Medical Authorization

Name of Child: _____ **Date of Birth:** _____

Name of Parent (s) or Guardian: _____

Home Address: _____, _____, _____
Street **City** **Zip**

Mother's Work Address: _____ **Phone#:** _____

Father's Work Address: _____ **Phone#:** _____

The Parent(s)/ Guardian authorizes A Child's Place at Hollin Hall ,
to provide immediate medical care and consents to the 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 emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers only when he/ she expects to be notified immediately. I authorize emergency medical personnel to transport my child to a medical facility to receive immediate medical attention.

1.) **I will be responsible for payment of medical care expenses** _____
Please sign/initial above

2.) **Medical Treatment costs are covered by:**

a.) **Blue Cross/ Blue Shield Policy Number:** _____

b.) **Medicaid Coverage Number:** _____

c.) **Other: Name of Insurance Company:** _____

Policy Number: _____

3.) **No Insurance:** _____

Child's Physician or clinic attended: _____

Child's Allergies (if any): _____

Child's Doctor: _____ **Phone#:** _____

Family Doctor: _____ **Phone#:** _____

Medications child is taking: _____

Last Tetanus Shot: _____

Outstanding Medical History (i.e. diabetes, heart disease): _____

Signature: _____ **Date:** _____