A Child's Place at Hollin Hall

1500 Shenandoah Rd, Alexandria VA 22308; 703-765-8811 (office); 703-765-7801 (fax); office@hollinhall.com

EMERGENCY MEDICAL AUTHORIZATION FOR CHILD

***Please complete ALL fields**. Incomplete registration forms will be returned for completion.*

CHILD'S INFORMATION

CHILD'S FULL NAME	NICKNAME	SEX	DATE OF BIRTH (MM/DD/YYYY)

CHILD'S (FULL MAILING) HOME ADDRESS	HOME PHONE NUMBER ( )

CHRONIC PHYSICAL PROBLEMS / PERTINENT DEVELOPMENTAL INFORMATION / SPECIAL ACCOMODATIONS NEEDED:

PARENT/GUARDIAN INFORMATION

PARENT FULL NAME		PARENT FULL NAME	
WORK ADDRESS		WORK ADDRESS	
MOBILE NUMBER	WORK NUMBER	MOBILE NUMBER	WORK NUMBER

MEDICAL INFORMATION

ALLERGIES OR INTOLERANCE TO FOOD, MEDICATION, ETC.	**ACTION TO TAKE IN AN EMERGENCY**:
CHILD'S PHYSICIAN OR CLINIC	PHONE NUMBER ( )

MEDICATIONS CHILD IS TAKING

OUTSTANDING MEDICAL HISTORY (i.e. diabetes, heart disease, etc):

LAST TETANUS SHOT	PRIOR HOSPITALIZATIONS OR SURGERIES

INSURANCE INFORMATION

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 their child/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.

I will be responsible for payment of medical care expenses (please sign):

Medical Treatment costs are covered by (please indicate name of insurance):

Insurance Policy Number:	Insurance group number:

I do not have medical insurance (please sign):

I hereby acknowledge that this information is up to date. I will promptly inform A CHILD'S PLACE AT HOLLIN HALL of any changes or updates to the above information as needed (please sign).

NAME: _____ DATE: _____