TRINITY PRESCHOOL EMERGENCY TREATMENT FORM

I,_____, hereby authorize any physician member of
(parent or guardian)

the Department of Emergency Medicine of Inova Fairfax Hospital or Arlington Hospital Center and/or any member of the Medical staffs of the above mentioned hospitals 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 or dependent)

_____
(Address)

_____
(Phone numbers)

Child's Birthdate_____

Child's Allergies (if any) _____

Childs's Dr. _____ Tele. No._____

Family Dr. _____Tele. No._____

Home, Work and Cell Phone Nos. _____

_____

Medicines Child is Taking _____

Outstanding Medical History (ex. Diabetes, Heart Disease)

_____

Insurance co. and Policy No. _____

Date of Last Tetanus Shot _____

_____
Signature of Parent or Guardian Date