LOGOS
ACADEMY

INOVA HEALTH SYSTEM

Authorization for Emergency Treatment

I,_____, hereby authorize any physician
(PARENT OR GUARDIAN's name, please print)

member of the Department of Emergency Medicine of Fair Oaks Hospital, Fairfax Hospital, Emergency Care Center of Reston / Herndon, and Mount Vernon Hospital 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)

Child's Date of Birth: _____

Child's Allergies (if any): _____

Child's Dr.: _____ Telephone #: _____

Medicines Child is taking: _____

Date of Last Tetanus Shot: _____

Outstanding Medical History (ex. Diabetes, Heart Disease, etc.): _____

Insurance Information

Insurance Company: _____

Identification / Policy #:_____

Subscriber's name: _____

Subscriber's Place of Employment: _____

Subscriber's Telephone No.: _____

The school has my permission in an emergency when I and my emergency contact cannot be reached, to send my child to the emergency room of the nearest hospital, and the hospital and its' medical staff have my authorization to provide any treatment which a physician deems necessary for the well-being of my child.

ALL PARENTS AND GUARDIANS ARE RESPONSIBLE FOR MAINTAINING THIS CONSENT FORM AS IT CANNOT BE MAINTAINED BY THE HOSPITAL.

Parent Signature _____Date_____