MEDICAL AUTHORIZATION FORM

INOVA Health System

Student Information

Student Name: _____ Date of Birth: _____ / _____ / _____
(mo.) (day) (4-digit year)

Grade: _____

Emergency Treatment Authorization

In the event that I or my spouse is unavailable by phone, or treatment should be given immediately, I, _____(Parent/Guardian's Name), hereby authorize any physician member of the Department of Emergency Medicine of **INOVA Health System** and/or any member of the Medical Staffs hospitals requested by the Department of Emergency Medicine physician, to render medical treatment, which in his judgment may be deemed necessary in the care of my child listed below. In the event my child is on a school activity closer to other emergency medical facilities, I extend this authority to the emergency medical physicians of those facilities.

_____ /_____ _____
Parent/Guardian Name Signature Date

Medical Data

Please check one of the following:

☐ My child is **not** allergic to any medications.

☐ My child is allergic to:

☐ Aspirin ☐ Other (identify) _____

Physician:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Medicines Child is Taking: _____ Last Tetanus Shot:_____

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

_____

Insurance Information

Insurance Company:_____ Plan #:_____

Group:_____ Hospital:_____

Subscriber's Telephone No.: (Home)_____ (Office) _____

Spouse:_____ Phone: (Home)_____ (Office) _____