

## GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH CARE REGULATION AND LICENSING ADMINISTRATION



## PLEASE TYPE OR PRINT

## AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child	, date of birth, month/day/year			
becomes ill or involved in an a Provider to give the emergency	accident and I cannot	be contacted, I authori	month/day/year ze the following hospital o	or Health
Hospital:				
Address:				
	or	:		
Health Provider:	M.D./N.P.	Telephone No:	(Area Code)	
Address:				
I give permission to		Name of Facility or Caretaker	, locate	ed at
			d:	
Medicaid Number:		_ State: DC [	☐ MD ☐ VA	
Child's Known Allerg (If yes, explain here:	ies or Health Condit	ions: Yes	No 🗌	
Home Address:	Street	City/State	Zip Code	
Area Code/Telephone N	Home	Business	Pager/Cell Phone	
Signature:			<u> </u>	
Relationship to Child:				
Date:	av/vear			