



**DIVISION OF EARLY LEARNING  
Licensing and Compliance Unit**

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PLEASE TYPE OR PRINT

**AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT**

If my child \_\_\_\_\_, born on \_\_\_\_\_, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

OR:

Physician: \_\_\_\_\_ M.D. Telephone No: \_\_\_\_\_  
(Area Code)

Address: \_\_\_\_\_

I give permission to \_\_\_\_\_, located at  
Name of Facility or Caretaker  
\_\_\_\_\_, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Coverage: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ State:  DC  MD  VA

Child's Known Allergies or Physical Conditions: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No: \_\_\_\_\_  
Home Business Pager/Cell Phone

Date: \_\_\_\_\_ Date Updated: \_\_\_\_\_  
Month/Day/Year Month/Day/Year

**NOTE: Place on file in child's folder/record**