Print

FAMILY DAY HOMES
CHILD'S EMERGENCY MEDICAL AUTHORIZATION
(MODEL FORM)

Name of Child _____ Date of Birth _____

Name of Parent(s) or Guardian _____

Home Address _____ Telephone _____

Place of Mother's Employment _____

Address _____ Telephone _____

Place of Father's Employment _____

Address _____ Telephone _____

The parent(s)/guardian authorizes _____
Name of Licensed Provider

to obtain immediate care and consents to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to his/her child if an emergency occurs when he/she cannot be located immediately, with the following exceptions: _____
_____

It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately.

1. I/we will be responsible for payment of medical care expenses. _____Yes _____No

2. Medical treatment costs are covered by:

   a. Medical Insurance:
      Name of Insurance Company: _____

      Identification Number: _____

      Group Number: _____

   b. No Insurance: _____

Child's Physician _____ Telephone _____

Address _____

_____ _____
Signature of Parent or Guardian Date

This form is to be kept by the licensed family day provider and is to be taken to the doctor or treatment facility in case of emergency.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
032-05-338/6 (1/05)