

Authorization for Treatment of Minors

In absence of Parents and/or Guardians

We/I _____ Street Address, City, State and Zip Code _____

Telephone Number _____ Give permission to: _____
(include area code) (must be 18 years of age or older)

to authorize emergency treatment at Sentara Potomac Hospital's Irene V. Hylton Emergency Care Center for our/my child/children:

	Child's Full Name	Age	Date of Birth	Date of last DPT/Tetanus	Medicine Allergies
1.					
2.					
3.					

Date: From: _____ To: _____ (must be specific)

Child/Children's Pediatrician/Family Physician _____ Telephone Number: _____
(include area code)

Any known illness (asthma, epilepsy, diabetes, etc.) and routine medications given. (List per child) _____

Telephone number and area code where parent/guardian may be reached: _____

Nearest Relative's Name: _____ Telephone Number: _____
(other than parent/guardian) (include area code)

Name of Insurance Company: _____ Policy Number: _____

Subscriber Name: _____ Employed by: _____

If possible, make a copy of subscriber's insurance card (front and back) and attach to form. All commercial insurances must have signed form brought in to ensure billing for your convenience. An effort will be made to contact parents or guardians before implementation of this form. This form should be kept with the adult responsible for the child's care when a parent or legal guardian is not present. Make copies as necessary. **NOTE:** Please sign the form in the presence of a Notary Public.

Signature - Parent/Legal Guardian

Date

County / City of _____
Commonwealth of Virginia
On this _____ day of _____

_____ personally appeared before me and acknowledged that he/she executed the foregoing instrument.

Notary Public

My commission expires: _____

Notary Registration # _____

(notary seal)