

# Medical Authorization Form

## INOVA Health System



### STUDENT INFORMATION

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\_\_\_\_\_  
Last Name First Name MI

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade entering: \_\_\_\_\_

### EMERGENCY TREATMENT AUTHORIZATION

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In the event that I or my spouse is unavailable by phone, or treatment should be given immediately, I 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's Name Parent/Guardian's Signature Date

### MEDICAL DATA

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My child is **not** allergic to any medications.  My child is allergic to: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician Phone

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Medicines Child is Taking Last Tetanus Shot

Outstanding Medical History (i.e., Diabetes, Heart Disease, etc.): \_\_\_\_\_  
\_\_\_\_\_

### INSURANCE INFORMATION

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Insurance Company: \_\_\_\_\_ Plan #: \_\_\_\_\_

Group #: \_\_\_\_\_ Hospital: \_\_\_\_\_

Subscriber's Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouse's Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_