KIDDIE COUNTRY DEVELOPMENTAL LEARNING CENTER
9601 OLD KEENE MILL ROAD, BURKE, VA 22015
703-644-0066 FAX: 703-644-0073 WWW.KIDDIECOUNTRY.COM

AUTHORIZATION FOR EMERGENCY TREATMENT

CHILD'S NAME:	DATE OF BIRTH:
HOME ADDRESS:	HOME PHONE:
NAME OF PARENT(S)/GUARDIAN:	

MOTHER

Address (If Different):	Home Phone:
Place of Employment:	Cell Phone:
Business Address:	Business Phone:

FATHER

Address (If Different):	Home Phone:
Place of Employment:	Cell Phone:
Business Address:	Business Phone:

CUSTODIAL GUARDIAN (Other Than Parent)

Address (If Different):	Home Phone:
Place of Employment:	Business Phone:
Business Address:	

CHILD'S ALLERGIES (IF ANY)	
CHILD'S DOCTOR	PHONE
FAMILY DOCTOR	PHONE
DAILY MEDICATIONS	LAST TETANUS SHOT
OUTSTANDING MEDICAL HISTORY (EX: DIABETES, HEART DISEASE, ETC.)	
INSURANCE COMPANY	IDENTIFICATION/POLICY NUMBER
SUBSCRIBER'S NAME:	SUBSCRIBER'S PHONE:
SUBSCRIBER'S PLACE OF EMPLOYMENT:	

I, ______________________________ hereby authorize any physician and/or any member of the
Parent or Guardian
medical staff of any emergency medical facility, requested by the physician, to render medical treatment which in his/her judgement may be deemed necessary in the care of ______________________________
Name of Child or Dependent

PARENT OR GUARDIAN SIGNATURE: ______________________________

STATE OF VIRGINIA
COUNTY OF FAIRFAX, to-wit:

I, the undersigned Notary Public in and for the State and County aforesaid, do hereby certify that ______________________________ whose name is signed to the foregoing authorization, has personally appeared before me in the State and County aforesaid and acknowledged the same.

Given under my hand and seal this ____________________ day of ______________________________

______________________________ ______________________________
My Commission Expires Notary Public

RV 1/5/18