



PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child _____, date of birth _____, month/day/year

becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or Health Provider to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Health Provider: _____ Telephone No: _____
M.D./N.P. (Area Code)

Address: _____

I give permission to **Two Rivers Public Charter School**, located at **TR4ES - 1227 4th Street NE, TRMS - 830 26th Street NE, TRYoung - 820 26th Street NE**, 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 Health Conditions: Yes No
(If yes, explain here: _____

Home Address: _____
Street City/State Zip Code

Area Code/Telephone No: _____
Home Business Pager/Cell Phone

Signature: _____

Relationship to Child: _____

Date: _____
month/day/year