



DISTRICT OF COLUMBIA  
OFFICE OF THE STATE SUPERINTENDENT OF

# EDUCATION

***DIVISION OF EARLY LEARNING  
Licensing and Compliance Unit***

**AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT  
(Update Annually)**

If my child \_\_\_\_\_, born on \_\_\_\_/\_\_\_\_/\_\_\_\_, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

or:

Physician: \_\_\_\_\_ M.D. Telephone No: \_\_\_\_\_  
(Area Code)

Address: \_\_\_\_\_

I give permission to \_\_\_\_\_, located at  
Name of Facility or Caregiver  
\_\_\_\_\_, 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 Physical Conditions: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No: \_\_\_\_\_  
Home Business Cell Phone

Date: \_\_\_\_\_ Date Updated: \_\_\_\_\_  
Month/Day/Year Month/Day/Year

**Place in child's folder/record.**