1609 Great Falls Street
McLean VA 22101

703.356.4691
www.LewMontessori.school

LEWINSVILLE
MONTESSORI

Authorization for Emergency Treatment

I _____, hereby authorize any physician member of the Department of Emergency Medicine of Commonwealth Hospital, The INOVA Fairfax Hospital ACCESS, The Virginia Hospital Center and/or any member of the above mentioned 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 _____.
(child's name)

Child's Allergies (if any): _____
Child's Dr. _____ Telephone #: _____
Family Dr. _____ Telephone #: _____
Medicines child is taking _____
Last tetanus shot _____
Outstanding medical history (diabetes, heart disease, etc.) _____

Insurance Information:

Insurance Company _____
Identification/Policy No. _____
Subscriber's Name: _____
Subscriber's place of employment _____
Subscriber's Telephone No. _____

I understand that it is my responsibility to keep this information up-to-date and to inform Lewinsville Montessori School administration of any changes.

_____ _____
Parent Signature **Date**