AUTHORIZATION FOR TREATMENT OF MINORS IN ABSENCE OF PARENT AND/OR GUARDIAN
POTOMAC HOSPITAL – WOODBRIDGE, VIRGINIA

I, ______________________________, give permission for an employee of Dale City Baptist Early Learning Program to seek emergency medical treatment at Potomac Hospital.

Child's Name: ____ Date of Birth: _______________________

Physician's Name: ____ Phone: ____________________________
Shot Records Attached

Allergies (Food, bee or wasp stings, drugs): ____

Indicate related reaction(s): ____

Chronic Illnesses: ____

Describe any abnormalities with regards to:

Speech: ____

Muscular Control: ____

Skin: ____

Other: ____

Please give any restrictions concerning the above abnormalities with regard to participation in typical preschool activities. (Use back of paper)

Routine medications given: ____

Is Child Allergic to Band-Aids ________ Yes _______ No (please initial)

Name of Insurance Company ____

Address: ____
Street *City* *State* *Zip Code*

Policy Number: _______________________________________ Name of Insured ______________________________

***************** NOTARIZATION REQUIRED BELOW *****************
Your signature below needs to be witnessed by a Notary Public. Please have your driver's license ready when signing.

____
Parent's (or guardian's) Signature

____
Date

Subscribed and sworn to me this ______ day of __________________, _______

Notary Public, County of Prince William – Commonwealth of Virginia

__________________________________ __________________
Notary Signature *Date Commission Expires*