EMERGENCY CARE FOR YOUR CHILD

Full name of child: ____

Address: ____________________________City:______________State:_____Zip_________

Date of Birth: _______/______/_______________ Date of Last Tetanus Shot: _______________
Month Day Year

Allergies or Chronic Problems (Examples: asthma, allergy to penicillin, heart murmur, diabetes):
____

List Medication the Child is Taking: ____

Name of Family Doctor: ___________________________ Telephone: ____________________

Name of Family Dentist: ___________________________ Telephone: ____________________

Health Insurance Coverage: Company: _______________ Policy/Group Number: ________

Parent or Guardian Name(s): ____

****Phone Number(s) Where Parent or Guardian Can Be Reached****

______________________ ______________________ _________________________

I hereby authorize the Emergency Department of Providence Hood River Memorial Hospital or other acute care facility to administer such examinations, diagnostic and medical treatment or surgery as may be necessary or advisable able for the health and well-being of my child.

For this reason it's important to have health information on each of your children readily available for relatives, babysitter, school personnel and others who may be present when an accident occurs. Providence Hood River Memorial Hospital will keep this form on file and a copy will be retained at your child's school. Our Emergency Department staff will make every effort to reach you if your child is brought in for treatment. With this information and authorization readily available, your child will be able to receive proper treatment and efficiently as possible.

PROVIDENCE HOOD RIVER MEMORIAL HOSPITAL…….541-386-3911 or
1-800-955-3911 (Gorge only)

AMBULANCE SERVICE…………………………………………………………..911

POISON CONTROL……………………………………………………..1-800-222-1222

FAMILY PHYSICIAN ____________________________ TELEPHONE _______________

Signature of Parent or Guardian: ___________________________ Date: _____________

Authorization for medical and/or surgical treatment and hospital service is valid for one (1) year from date of signature.