

# 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 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.