BROOKSFIELD SCHOOL

1830 Kirby Road ~ McLean, VA 22101
Office 703-356-5437
Fax 703-356-6620

STUDENT EMERGENCY TREATMENT FORM

I, ______________________________________, hereby authorize any physician member of the Department of Emergency *Fairfax Hospital, Urgent Care or* ____and any other member of the medical staffs of the above mentioned hospitals requested by the Department of Emergency Medicine physician, to render medical treatment, which in his/her judgment may be deemed necessary in the care of:

Name of Child ____
Address____
____
Phone:____

Complete home address and home phone for the child

1. ____
Name of parent and, if different, home address and home phone #

____
(work phone #) (cell phone #) email address

2. ____
(Name of parent and, if different, home address and home phone #)

____
(work phone #) (cell phone #) email address

Child's birth date__________ Child's allergies, if any______________________
No allergies___________(please put n/a if no allergies)

Medication child is taking____

Outstanding medical history (diabetes, heart disease, asthma etc.)

____
____

Child's doctor and phone #____

Medical Insurance and Policy #____

2015/16