10 PIDGEON HILL DRIVE
SUITE 70
STERLING, VIRGINIA
20165
OFFICE: (703) 4ED-0805

EMERGENCY CONTACT FORM

(PINK)

Name:______________________________ Birthdate:______________________ Age: ___________

Date Entered Into Program:_________________ SSN:___________________________ Sex: M / F

Address:____

City:________________ State:_____________________ Zip Code:___________________________

Phone:(H)_________________________________ (O)_______________________________

INCASE OF AN EMERGENCY CONTACT:

Name**:**____ Relationship:__________________________

Address (If different than above):____

City:___________________ State:________________________ Zip Code:______________________

Phone:(H)________________________________ (O)____

INSURANCE/MEDICAL:

Are you covered by any medical coverage/insurance? Yes ❑ No ❑

Insurance Policy Holder's Name: ____

Insurance Company:________________________________ Policy #:___________________________

Group#:_______________________Date of Policy:____

Employee#:____

Physician:_______________________________________ Phone:_______________________________

Dentist:____ Phone:_______________________________

Other:____ Phone:_______________________________

Allergies/Medical Alert:

I,________________________, give consent for my child,______________________________________ to receive immediate emergency medical care in my absence should such an event be necessary that he/she should require any emergency medical attention, treatment, medication, and/or surgery in efforts to save losses to hearing, sight, limb, and/or life.

Parent/Guardian Signature:_____________________________________ Date:_____________________

Witness/ED Anywhere Authorization:_____________________________ Date:____________________