Christ Memorial Presbyterian Church
6410 Amherst Avenue, Columbia, MD 21046 410-997-8011

EMERGENCY MEDICAL AUTHORIZATION

Date: _____

Child's Name: _____ Birthdate: _____

Parents' Names: _____

Address: _____

_____

Phone: (H) _____ (W) _____ (Cell) _____

If a parent/guardian cannot be reached at once, in case of accident or illness that does require immediate medical services, I/we give my/our permission for the staff or volunteers of CMPC to summon emergency medical services and to obtain necessary emergency hospital treatment. I/we acknowledge that I am/we are responsible for all reasonable charges in connection with the care and treatment rendered during this period.
(Indicate yes or no) _____

Signature (both parents): _____

Hospital service will require the following information before treatment:

Family physician's name: _____

Phone: _____

Allergies: _____

Medications taken regularly: _____

Any significant medical history: _____

_____

PAYMENT PLANS:
(a.) Treatment to be paid in cash by parent/guardian (indicate yes/no) _____
Or (b.) Treatment to be paid by insurance carrier (indicate yes/no) _____

Carrier Name: _____

Group #: _____ Agreement #: _____