Achieve Pediatric Therapy

Emergency Information 2015

Name of Child: ______________________________Date of Birth: ______________________

Address: ____

Pediatrician: ______________________________ Phone: __________________________

Dentist: __________________________________ Phone: __________________________

Other medical provider: ____________________ Phone: __________________________

Allergies or Restrictions: ____

Mother's Name: ____________________________ Social Security #:___________________

Home Phone: _____________________________ Business Phone:___________________

Cell Phone: ______________________________ Other Contact: _____________________

E-Mail address: ________________________________

Father's Name: ____________________________ SocialSecurity#:___________________

Home Phone: _____________________________ BusinessPhone: ___________________

Cell Phone: ______________________________ Other Contact: _____________________

E-Mail address: ________________________________

Other Caregivers (i.e., babysitter, relative) who may be taking child to and from therapy:

Contact: _________________________ Contact:___________________________

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Relationship: _____________________________ Relationship: _____________________

Phone: ___________________________________ Phone: ____________________________

In the event of an emergency if the parent cannot be reached, please list 2 other contacts:

1. ____
2. ____

Emergency Medical Release:

Should my child need emergency medical care due to an accident or illness while I am absent from my child's therapy session, I grant permission to call 911 immediately and/or to perform routine medical care including CPR and First Aid. I am to be contacted immediately. If I cannot be reached, listed emergency contacts will be called immediately.

____________________________ ____________________

Parent/Guardian **Date**