Achieve Pediatric Therapy

OT – PT - ABA

Emergency Contact Information

Client Name: _____ Date of Birth: _____

Address: _____

Pediatrician: _____ **Phone:** _____

Dentist: _____ Phone: _____

Specialist: _____ 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: _____ Business Phone: _____

Cell Phone: _____ Other Contact: _____

E-Mail address: _____

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

Name: _____ Name: _____

_____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

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

1. _____ Phone: _____
2. _____ Phone: _____

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**