OT Solutions
Pediatric Occupational & Speech Therapy

EMERGENCY MEDICAL TREATMENT

Child's Name: _____ DOB:_____

Parent/Guardian: _____

Address: _____

Contact Numbers: _____(Cell) _____(Home)_____(Work)

Child's Physician: _____ Phone: _____

**Emergency Contact (if unable to reach parent/Guardian): _____

Phone _____

Please list any known allergies: _____

Please list any medical conditions that may require special precautions or treatment:

_____

_____

Please list current medications: _____

In the event of an emergency requiring medical aid/treatment due to illness or injury during the process of receiving services, or while on the property of OT Solutions Inc., I authorize OT Solutions Inc. to:

1) Secure and retain medical treatment and transportation
2) Release any records upon the request of the authorized individual or agency involved in the medical emergency treatment
3) Preferred facility for treatment (if able): _____

Parent/Guardian Signature_____ Date_____

Printed Name: _____

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