



AUTHORIZATION FOR EMERGENCY CARE

I _____ HEREBY AUTHORIZE THE STAFF AT **CHILDREN'S THERAPY OF WOODINVILLE** TO CALL FOR APPROPRIATE EMERGENCY MEDICAL TREATMENT FOR _____.

SIGNATURE OF PARENT / LEGAL GUARDIAN

DATE

Child's Birthdate: _____

Allergies: _____

Medicine child is allergic to:

What medications is your child on currently?

Pertinent medical history that would affect emergency care.

Cell Phone #: _____

Parent Name: _____

Parent Address: _____

Insurance Co.: _____

Subscriber Name: _____

Insurance ID Number: _____