8200 Georgia Street
Merrillville, IN 46410

Phone: 219-791-1400
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## CONSENT TO EMERGENCY TREATMENT AND TRANSPORTATION

Parents or Legal Guardians are requested to complete the following information in the event emergency treatment is required and there is a need to transport your child for emergency medical treatment.

### EMERGENCY INFORMATION

Patient Name & address: ____________________________________________

Sex: M __ F ___ Age: __________ Date of Birth: _____/_____/_____

Emergency Contact Name: _________________________ Relationship _________

Work/Cell Phone: _______________ Cell/Home Phone: _____________________

Additional Emergency Contact: __________________ Relationship: ___________

Work/Cell Phone: _______________ Cell/Home Phone: _____________________

Insurance Name: ____________ Policy & Group Numbers: ___________________

**ALLERGIES:**

_______________________________________________________________

### CONSENT OF PATIENT OR GUARDIAN AUTHORIZING TREATMENT

I hereby give my consent to Innovations In Learning to consent on my behalf to emergency treatment and/or emergency transportation to the nearest hospital emergency room.

Patient or Guardian Signature: ______________________ Date: ___________

Witness: _________________________________ Date: ____________
Position at Innovations