8200 Georgia Street
Merrillville, IN 46410

Phone: 219-791-1400
Fax: 219-791-1422

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: _____/_____/_____

Parent/Guardian Name:____

Work/Cell Phone:_____________________ Home Phone:_________________________

Parent/Guardian Name: ____

Work/Cell Phone:__________________ Home Phone:______________________

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