Innovations In Learning PC

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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 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: _____