

PROFESSIONAL THERAPIES, INC.
EMERGENCY INFORMATION

Patient's Full Name: _____ DOB: _____

Parent's/Guardian's Name (if child): _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Patient's Physician: _____ Phone: _____

Physician's Address: _____

Any other emergency contacts other than the one listed on the Patient Information Sheet: (Name & Phone)

ALLERGY INFORMATION: Please list anything that you or your child is allergic or has an adverse reaction to and what symptoms you or your child may demonstrate. Please indicate what to do in case an allergic reaction occurs. (Please include food, medicine, and animals when listing allergic reactions).

ITEM	SYMPTOMS	INSTRUCTIONS

RESTRICTIONS & PRECAUTIONS: During therapy, we may provide a snack & drink to your child. Please indicate any foods you do not want given to your child. Also, please indicate any other relevant precautions.

DO NOT GIVE MY CHILD ANY OF THE FOLOWING FOODS/DRINKS	OTHER PRECAUTIONS/RESTRICTIONS

EMERGENCY AUTHORIZED PICK-UP AND DROP-OFF CONTACTS:

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
Phone: _____	Phone: _____

RELEASE TO AUTHORIZE MEDICAL TREATMENT:

I, the patient or parent/guardian of _____, give my permission to the PTOR staff to authorize emergency medical or dental treatment for me or my child by a licensed physician or dentist, and for the transport of myself or my child to and from the source of the emergency treatment. I release PTOR and any of it's personnel from liability arising out of their activities in connection with authorizing such medical attention, and I agree to hold PTOR and it's personnel harmless from any expense arising there from. I understand that it is my responsibility to notify PTOR of any changes of the above in writing (i.e. filling out a new form) in a timely manner.

 Patient/Parent Guardian Signature

 Date