



Emergency Contact Information

Therapeutic excellence through innovation—integration—collaboration™

Please provide emergency contact information. Creative Health Solutions will contact the parent or authorized person and may contact Emergency Medical Services (911) in the event of a medical emergency involving your child.

Child's Name :			
Child's Pediatrician:		Phone:	
Child's 2 nd physician:		Phone:	
Phone numbers of mother/guardian:	Home:	Work:	Cell:
Phone numbers of father/guardian:	Home:	Work:	Cell:
Allergies and other relevant information:			

Persons authorized to take my child from the clinic (in addition to parents/guardians above):

Name:	Relationship:	Can we contact in emergency?	Home telephone:	Work:	Cell:

If emergency medical care becomes necessary, I understand Creative Health Solutions staff will call Emergency Medical Services (911).

I ___ allow ___ do not allow my child's health insurance information to be given to third party providers to facilitate treatment in emergency situations. My initials _____

_____/_____/_____
Signature, Parent or Guardian Date

I allow release of my child's health information to emergency medical staff and other medical personnel that may treat my child in the situations described above. (I understand that this release is voluntary and is **not** required to receive any services from Creative Health Solutions, including the services covered by this document. My initials _____ acknowledge this understanding, my signature below allows release of information.)

_____/_____/_____
Signature, Parent or Guardian Date

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