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| **Child(ren) Enrolled in Children FIRST Therapy** |
| Name (First MI Last) Sex Date of Birth: Start Date: M or F |
| Allergies: Child Care Provider: DDD# Address: Authorization# |
| Name (First MI Last) Sex Date of Birth: Start Date: M or F |
| Allergies: Child Care Provider: DDD# Address: Authorization# |
| **Parent(s)/Guardian(s)** |
| Last Name: First Name: Home Phone: |
| Last Name: First Name: Home Phone: |
| Street Address: Mailing address if different |
| City, Street, Zip Email Address |
| **Other Children in Household** |
| Name (First MI Last) Sex Date of Birth:  M or F |
| Name (First MI Last) Sex Date of Birth:  M or F |
| Name (First MI Last) Sex Date of Birth:  M or F |
| **Home Residence Information** |
| Child(ren)Live(s) With (circle One): Both Parents Mother Only Father Only Grandparents Mother & Stepfather Father & Stepmother Guardian Foster Family |
| Permission to have **photo** used in newspaper, educational display/video, brochure, social media or website. (circle one)  Yes No |
| I herby give permission for my child(ren) to be video taped for training purposes for Children FIRST Therapy. Names and personal information will not be used in the video. (circle one) Yes No |

**Children FIRST Therapy Emergency Contact Information**

**Emergency Contacts/Additional Persons Authorized for release of Child(ren)**

**Mother/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NOTE: THIS WILL BE A PERMANENT PART OF YOUR CHILD’S FILE. IT IS EXTREMELY IMPORTANT THAT YOU NOTIFY US OF ANY CHANGES AS THEY OCCUR.

I/We, the undersigned, guardian(s) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby consent to release medical information such as IFSP information or therapy information to the following person(s) in our absence. There is no court order in effect which would prohibit this authorization. We understand our right to revoke this consent at any time by notifying Children FIRST Therapy.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I/We, the undersigned, guardian(s) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

minor(s), do hereby authorize Children FIRST Therapy as agent(s) to consent to any x-ray, anesthetic, tests, transfusions, injections, drugs, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that all possible attempts will be made by Children FIRST Therapy to notify and/or locate the undersigned before proceeding with any medical treatment.

I hereby authorize Children FIRST Therapy to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical or surgical care, in case I am not immediately available.

I give authorization for the staff of Children FIRST Therapy to provide emergency medical care.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our afore said agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his best judgement, may deem advisable.

Emergency Medical Information:

Primary Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital of Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mark box for authorization

Mark box for authorization

**RELEASE OF MEDICAL INFORMATION**

**MEDICAL RELEASE**

**Special Circumstances we should be aware of (restraining or no-contact order): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| First & Last Name | Relationship | Primary Phone:Work/Cell Phone: |
| First & Last Name | Relationship | Primary Phone:Work/Cell Phone: |
| First & Last Name | Relationship | Primary Phone:Work/Cell Phone: |
| First & Last Name | Relationship | Primary Phone:Work/Cell Phone: |