



Pediatric Interactions Inc.

Helping Children Better Communicate

649 Barron Blvd
Grayslake, IL 60030
847.223.7433 fax 847-278-0458
www.PediatricInteractions.com

Emergency Treatment Release

This form must be presented to medical professionals in case of an emergency

Child's Name: _____ Date of Birth: _____

I/we, as parent(s)/legal guardian(s) hereby give permission the above-named child to participate in therapeutic activities at Pediatric Interactions Inc. I/we also give permission to Pediatric Interactions Inc. to secure medical and/or emergency treatment for the above-named child while in their care. This may include, but is not limited to first aid, care by a physician, paramedic or local hospital. In addition, I will update this information and any insurance information as changes occur.

AUTHORIZED PERSONS TO WHOM CHILD MAY BE RELEASED

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

MEDICAL INFORMATION

Are there any medical conditions that would be important for medical personnel to know? (e.g., blood type, diabetes, heart conditions, epilepsy, blood-born pathogens, etc.) _____

Please list all prescription medications currently taken (including purpose, dose, time(s) taken, side effects):

Please list all allergies (including medications, food and environmental): _____

Health Insurance Identification Information: _____

Physician: _____
Name Address Phone

Other Specialist: _____
Name Address Phone

Dentist: _____
Name Address Phone

Preferred Hospital/ER: _____

Emergency Contact

_____ Name	_____ Address	_____ Phone	_____ Relationship
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Parent/Guardian Signature _____ Date _____

Cell Phone: _____

Parent/Guardian Signature _____ Date _____

Cell Phone: _____