# EMERGENCY EVACUATION AND PICKUP AUTHORIZATION FORM

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Client’s Name: |  | Age: |  | DOB: |  |
| Address: |  |
|  | Street |  | City/Town | State | Zip |
| Gender: | Male |  | Female |   |  Diagnosis, if any:  |  |
| FAMILY INFORMATION |
| Parent/Guardian: |  |  |  |  |  |
| Daytime Phone: |  |  |  |  |  |
| Mobile Phone: |  |  |  |  |  |
| Email: |  |  |  |  |  |

## *Gwen Fowler-Berken, MS, CCC-SLP* CAN RELEASE MY CHILD FROM THERAPY TO THE FOLLOWING INDIVIDUALS

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## MEDICAL INFORMATION

|  |  |
| --- | --- |
| Name of Primary Physician:  |  |

|  |  |
| --- | --- |
| Physician Address:  |  |
|  |  |
|  |  |

Does the client take any prescription medications? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| List:  |  |

Does the client take any over-the-counter medications on a regular basis? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| List:  |  |

Please list any medical, environmental, or seasonal allergies:

Please list any significant health problems or diet needs (i.e., asthma, diabetes, etc.):

In the event that the client needs medical attention off-site, what hospital would you prefer the client to be taken too?

**Please read and sign below. Your signature and initials indicate that you are in agreement with the policies described below.**

Medical Emergency Policy

In the event that there is a medical emergency that requires the client to be immediately evacuated, every effort will be made to contact the parent/guardian first. Should the client require medical treatment off-site they will be sent to the hospital designated on this form as indicated by the parent/guardian. I understand that if a hospital is not otherwise indicated, that the client will be sent to the closest appropriate hospital as determined by emergency medical staff.

**\_\_\_\_\_Parent Initial**

In the event of a medical emergency, you give your consent for ***Gwen Fowler-Berken, MS, CCC-SLP*** to disclose the above information to medical personnel as deemed necessary to assist in the care and medical treatment for this client.

**\_\_\_\_\_Parent Initial**

|  |  |  |
| --- | --- | --- |
| *Parent signature* |  | *Date* |