EMERGENCY MEDICAL RELEASE

In the event that medical attention is required for your child while on the premises of APT, LLC, we need your authorization to implement treatment. Please read and sign below:

As legal guardian of ____________________________, I give my permission for APT to contact emergency personnel in the event of a medical emergency.

Parent/Guardian's Signature: ____________________________________Date: _____________

MEDICATION / ALLERGY / CONDITION

Medication: Please list all medication your child is currently taking, including prescription, non-prescription, vitamins and homeopathic substances.

____

____

Allergies:

____

____

Diagnosis: Please list all medical diagnoses or medical conditions below.

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PHOTO PERMISSION: Initials / Date

-I give permission for the photograph/videotape of my child to be used for the purposes of treatment, education and documentation. ________ / ________

-I give permission for the photograph/videotape of my child to be used for brochures, advertising and / or web space. ________ / ________

List the names of the Programs and people that have worked or are working with your child.

Service	Program Name	Teacher/Therapist	Phone #	Dates
Pediatrician/Physician				
Child Care Program				
Preschool/School				
Physical Therapist				
Occupational Therapist				
Speech Therapist				
Counselor/psychologist				
Infant Learning Program				
Head start Program				
Caseworker/care coordinator				
Other				