TRIANGLE
THERAPY SERVICES

Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Triangle Therapy Services to:

1. Secure and retain medical treatment and transportation if needed.
2. Release any records upon the request to the authorized individual or agency involved in the medical emergency treatment.

Please describe any medical conditions that may require special precautions or treatment and any medications you are now taking:

_____

_____

List any allergies:

_____

Client's Name: _____ Date of Birth: _____

Parents/ Guardian: _____

Address: _____

_____

Phones: Primary: _____ Text: Y or N

Secondary: _____ Text Y or N

Email: _____ You may contact me by email: Y or N

Physician's Name: _____ Telephone #: _____

Person to contact in emergency (if parent or guardian cannot be reached first):

_____ Contact #: _____

_____ _____ _____

Signature Date Relationship