CREATIVE BEHAVIORAL CONNECTIONS
creating connections to last a lifetime

5803 W. Craig Road, Suite 105, Las Vegas, NV 89130
Phone: 702-901-5200 Fax: 702-901-5201

EMERGENCY MEDICAL CONSENT FORM

_____ has my permission to obtain emergency medical treatment for my child, _____ when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

Mother/Guardian's Name _____
Home Phone _____ Cell Phone _____
E-mail Address: _____
Father/Guardian's Name_____
Home Phone _____ Cell Phone _____
E-mail Address: _____
My insurance provider is _____
Preferred hospital/treatment center _____
My child is taking the following medications _____
_____
My child has the following allergies _____
_____

Comments on child, family, or other specific medical issues:

☐ I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is receiving therapeutic services at Creative Behavioral Connections or at home in my absence.

_____ _____
Signature of Parent or Guardian Date