

EMERGENCY CONTACT AND MEDICAL INFORMATION

Client's Name

Date of Birth

Sex

Home Phone

Cell Phone

Email Address

Address

City, ST ZIP Code

EMERGENCY CONTACTS

Primary Emergency Contact (Name; Relationship to Client)

Secondary Emergency Contact (Name; Relationship to Client)

Home Phone

Cell Phone

Home Phone

Cell Phone

Address

Address

City, ST ZIP Code

City, ST ZIP Code

MEDICAL INFORMATION

Physician's Name

Phone Number

Insurance Company

Policy Number

Medication(s) Taken and Dosage

Allergies

Any medical condition(s) the clinic should be aware of (ex: diabetes, broken bones, head injuries, etc.)

I give permission for the CSULB Speech and Language Clinic to treat my child/spouse or bring them to the emergency room if I am not available for consent.

Print Name

Signature

Date