

**OT 4 KIDs**  
**751 Alameda de las Pulgas**  
**Belmont, CA. 940021**  
**Phone :(650) 592-1112**

**Informed Consent and Emergency Information**

Movement and the use of moving equipment are integral to our therapy program. We will make every effort to ensure your child's safety. We do however want you to be aware that it is possible for accidental injuries to occur in this environment. In addition please be aware that physical contact with the therapist is common in sensory treatment programs.

Please provide us with emergency contact information and sign below your informed consent to provide occupational therapy treatment to your child. It is our sincere hope that this information will never be necessary but important to have on hand.

I give permission for my child \_\_\_\_\_ to receive an occupational therapy evaluation or treatment at OT 4 KIDs. Signature of both parents is required. In the event of the need for emergency medical attention, I give my consent for 911 personnel to provide essential care.

\_\_\_\_\_  
Mother's Signature Date

\_\_\_\_\_  
Father's Signature Date

**Emergency Information**

**Mother**

**Father**

**Name:** \_\_\_\_\_

Home \_\_\_\_\_

Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Pager: \_\_\_\_\_

**Other Emergency Contact Person:**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Child's Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child have any medical conditions or physical limitations? \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_