

Carruth Center, Inc



11001 Hammerly Blvd. Houston Texas 77043 713-935-9088 713-935-0654 (fax)

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

Child's Name (Print): _____ Birth Date: _____

Mother's Name: _____ Father's Name: _____

Mother's Home #: _____ Father's Home #: _____

Mother's Work #: _____ Father's Work #: _____

Mother's Mobile #: _____ Father's Mobile #: _____

In the event that we cannot be reached to make arrangements for emergency medical attention, we authorize Nicole Devens, Clinical Director, or a designated staff member to take my child to:

Dr. _____

Address: _____

Phone #: _____

Or to the nearest hospital, and we give our consent for any and all necessary treatment. In case of emergency treatment, please inform the medical staff that our child has the following allergies:

and that our child take the following medication(s) on a daily basis (include dosage):

Please list two (2) persons whom we may contact in the event of any emergency:

_____	_____	_____
Name	Phone	Relationship

_____	_____	_____
Name	Phone	Relationship

_____	_____
Mother's signature & Date	Father's signature & Date

THIS FORM MUST BE KEPT UPDATED AT ALL TIMES.