LAKESHORE
SPEECH THERAPY, LLC.

Emergency Medical Authorization Form

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the authority of Lakeshore Speech Therapy, LLC, when parents or guardians cannot be reached.

Child's Name_____

PART I- To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor_____Phone_____

Local Hospital_____Phone_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for:

1) The administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practioner is not available, by another licensed physician;
2) The transfer of the child to any hospital reasonably accessible.

Signature of Parent or Guardian_____

Print Name_____ Date_____

PART II- Refusal to Consent

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish Lakeshore Speech Therapy, LLC to take the following action:_____

Signature of Parent or Guardian_____

Print Name_____Date_____