STONES WORTH STEPPING, P.C.
PEDIATRIC PHYSICAL, OCCUPATIONAL & SPEECH THERAPY

Feeding & Swallowing Therapy: Emergency Medical Form

Child's Name: _____

Person Completing Form/Relationship to the Child: _____

Date: _____

Allergies *(Note: Your child will be required to wear a wristband throughout his/her feeding session, indicating any potential allergies. This will be provided when your child checks in.)*

Allergy	Onset	Reaction

Emergency Contact Information

Parent Name: _____

Phone Number: _____

If I cannot be reached in case of a medical emergency, please contact the following individual:

Name/Relationship to the Child: _____

Phone Number: _____

Medical Contact Information

Pediatrician's Name: _____

Address: _____

Phone Number: _____

Pulmonologist's Name: _____

Address: _____

Phone Number: _____

In case of an emergency, I prefer for my child to be transported to the following hospital:

_____