Sensory Solutions, LLC
322 Los Gatos – Saratoga Rd.
Los Gatos, CA 95030
Clinic Phone/Fax: (408) 647-2084
Direct: (408) 891-3119

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 occupational therapy treatment at Sensory Solutions. 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:_____
Email:_____

Other Emergency Contact Person:
Name_____Relationship:_____
Phone Numbers:_____
Child's Pediatrian:_____Phone:_____
Does your child have any medical conditions or physical limitations?_____
_____
Known Allergies:_____
Current Medications:_____