TRIANGLE
THERAPY SERVICES

Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Triangle Therapy Services to:

1. Secure and retain medical treatment and transportation if needed.
2. Release any records upon the request to the authorized individual or agency involved in the medical emergency treatment.

Please describe any medical conditions that may require special precautions or treatment and any medications you are now taking:

_____

_____

List any allergies:

_____

Client's Name: _____ Date of Birth: _____

Parents/ Guardian: _____

Address: _____

_____

Primary phone: _____Name: _____

Other phone: _____ Name: _____

Email: _____ You may contact me by email: Y or N

Physician's Name: _____ Telephone #: _____

Person to contact in emergency (if parent or guardian cannot be reached first):

_____ Contact #: _____

Signature Date Relationship

*911 West Main St. Eaton, OH 45320 * Phone: 937 456-6505 * Fax: 937 456-6505*
*info@triangletheapyservices.com * www.triangletheapyservices.com*

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RELEASE FORMS

Registration and General Release Form

I, _____ (Parent/Legal Guardian's Name), hereby apply for participation in Triangle Therapy Services, LLC summer programs or hippotherapy program. I acknowledge the risks and the potential for risks of the program's use of horses, other animals, and nature activities. However, I feel that the possible benefits are greater than the risks assumed. I hereby forever release, discharge, and hold free and harmless, for myself, my heirs and assign, executors or administrators, all claims for damages against Triangle Therapy Services, LLC, its therapists, instructors, aides, volunteers, and /or employees, and the Benge Farm of any and all injuries and/or losses the client, client's family, or guests may sustain while participating in any programs.

_____ _____

Signature of Parent/Legal Guardian Date

Photo Release

I consent to and authorize the use of reproduction by Triangle Therapy Services, LLC of any and all photographs and any other audiovisual materials take of the client, client's family, or guests while in treatment for use in promotional materials, educational activities, exhibitions, or for any other use of the benefit of Triangle Therapy Services, LLC. I also give consent for pictures (without names) to be posted on the Triangle Therapy Services, LLC facebook page.

_____

Signature of Parent/Legal Guardian Date

Damage Release

I, _____ (Parent/Legal Guardian's Name), hereby agree that I will be responsible for seeing that any children or guests brought by me on the premises of Triangle Therapy Services, LLC are properly supervised at all times while on such premises. I agree to not bring any animals onto the property. I further agree that I will be liable for any damage to the property of Triangle Therapy Services, LLC or the Benge home, and/or for any loss of use of such property resulting from any such damage, caused by my negligence or that of any child or guest brought on such premises by me. I further agree to pay for any necessary repairs or to reimburse Triangle Therapy Services, LLC and/or the Benge family for the reasonable cost of repair, replacement, and/or loss of use of such property pending repair or replacement.

_____

Signature of Parent/Legal Guardian Date

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SUMMER PROGRAM PARTICIPATION AGREEMENT AND CLIENT HISTORY

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

GENERAL INFORMATION

Client Name: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ Male or Female

School System: _____ Grade: _____

THERAPY HISTORY

What therapy services is the client currently receiving and where? (OT/PT/ST/counseling)

School: _____

Private: _____

HEALTH HISTORY

Medical diagnoses: _____

Medications: _____

Food restrictions: _____

Allergies: _____

Please give a brief description of your child in each of the following aeas.

Vision: _____

Hearing: _____

Sensory issues: _____

Cardiovascular: _____

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Seizures: _____

Pain/Joint/Muscular: _____

Behavioral: _____

Thinking/Cognition: _____

CLIENT SNAPSHOT
(Give us a picture of your child in the following areas)

Gifts/Talents: (Strengths, what your child brings to the group)

Physical function: (mobility, equipment, transfers, level of supervision needed)

Language: (approximate # of words, signs, sentences)

Self care: (toileting status, feeding status)

We will not routinely change diapers/assist with toileting during groups unless it is a necessity. Please change your child right before the session starts. If changing is required, do you give permission for a staff member to change your child/assist in the bathroom: Y or N

Social/Behavioral: (Describe your child's personality or any behavioral approaches used)

Goals: (What would you like your child to receive from this program?)

We look forward to working with your child.

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