Lisa M. Satalino, PT

407 Albany Shaker Rd.

Loudonville, NY 12211

518-339-5792

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Today’s Date:

Gymnast Name:

Gymnast Date of Birth:

Level:

Parent Name:

Parent Contact Information:

Best Phone Contact:

E-mail address

Address:

Physician Name:

Physician Contact Information:

Phone number:

Address:

Parental Consent: I give permission for Lisa M. Satalino, PT to perform a physical therapy evaluation and to administer a physical therapy treatment plan to my child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_I give permission for Lisa M Satalino, PT to provide my child with Cold laser Treatments.

Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_