Camp / Group Enrollment Form

Child's Name:		DOB:		
Address:		Gender:	M	F
City, State, Zip Code:				

Parent/Guardian:		
Relationship to Child:		
Mailing Address:		
Email Address:		
Best Contact Numbers:	Cell#:	Home#:

Parent/Guardian:		
Relationship to Child:		
Mailing Address:		
Email Address:		
Best Contact Numbers:	Cell#:	Home#:

Primary Physician:		Telephone:	
Physician's Address:			

Emergency Contacts

Although we never anticipate an emergency, in the event there is an emergency and we are unable to reach the parents/guardians listed, Amazing Kidz Therapy may contact the individuals below regarding your child:

Name:		Phone#:	
Name:		Phone#:	

Consent to Treat

I hereby authorize Amazing Kidz Therapy, PLLC and their therapists to perform evaluations and/or treatment to my child.

Parent/Guardian Signature: _____ Date: _____

Release of Information

I hereby authorize Amazing Kidz Therapy, PLLC to obtain and release information regarding my child to all listed insurance carriers. In addition, Amazing Kidz Therapy, PLLC may release and discuss information regarding my child, including but not limited to, evaluations, reports, progress notes and records, to the following organizations, practices and / or individuals:

_____

_____

_____

Emergency Care

In case of medical emergency, due to illness or injury during the process of receiving services, or while on property, I authorize Amazing Kidz Therapy, PLLC to:

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

Any and all costs for emergency medical care will be the responsibility of the parent/guardian of the child including, but not limited to transportation, urgent care and medical treatment.

Parent/Guardian Signature: _____ Date: _____

Financial Responsibility

All Camps / Groups are all private pay. For your convenience, we accept cash, checks and most major credit cards. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $25, in addition to any costs assessed or charged by any depository institution. Checks $300 and over will be charged 10% of the amount of the check surcharge.

Parent/Guardian Signature: _____ Date: _____

Medical History

Diagnoses

Please list all diagnoses that have been given to your child & the approximate date in which they were made.

_____

_____

_____

Medications

Please list all current medication and dosage that your child currently takes.

_____

_____

_____

Allergies

Please list any and all allergies that your child may have. If they and/or you carry an EpiPen, please indicate that below.

_____

_____

_____

Sensory

Does your child have any hearing difficulties?	Y	N
Does your child have any low vision difficulties?	Y	N

Please list any sensitivities that your child may have (i.e. certain sounds that may cause distress):

_____

_____

_____

Cancellation/Sick Policy

Cancellation Policy

No refunds will be issued for any sessions that your child may miss.

Sick Policy

In order to keep all our friends healthy, we ask all visitors, including clients, parents and siblings, to adhere to our sick policy. We ask that no one enters the building until being symptom free form all viral and bacterial illness for a minimum of 24 hours. This includes fever, vomiting, diarrhea, green nasal drainage, eye drainage, and / or on antibiotics for a minimum of 24 hours for all contagious diagnosis.

Childs Name: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Media Release and Consent

Please choose ONE of the following options to indicate your preference for your child.

□ I hereby authorize Amazing Kidz Therapy, PLLC to photograph and/or videotape my child to utilize for any and all marketing, social media and/or publications as they see fit.

□ I hereby authorize Amazing Kidz Therapy, PLLC to photograph and/or videotape my child ONLY during group therapy treatment sessions, where my child will not be the only child within a picture, to utilize for any and all marketing, social media and/or publications as they see fit. I DO NOT authorize individual pictures of my child to be utilized.

□ I DO NOT authorize Amazing Kidz Therapy, PLLC to utilize any photographs of my child for marketing, social media or other purposes.

Childs Name: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Relationship to Child: _____

Release for Appointment Reminders

I, _____ (Print), hereby authorize Amazing Kidz Therapy, PLLC to send mean appointment reminder via e-mail or text message using the following information:

Email and/or text message reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Depending upon Cell Phone service provider and personal calling/messaging plan, text messaging rates may apply and are the responsibility of the Patient/Guardian listed below.

Patient / Guardian Contact Information:
(Please print clearly and legibly)

E-mail: _____

Cell phone: _____

Patient / Guardian (Print): _____

Signature: _____

Date: _____

Note to Office Managers: Confirm that the E-mail and Cell Phone provided above match the information in the patient information screen.

Waiver and Release of Liability

In consideration of the risk of injury while participating in therapy treatment and services (the "Activity"), and as consideration for the right to participate in the Activity, I hereby, for myself and my child, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my child's participation in therapy services, in both individual and group settings, and do hereby release and forever discharge Amazing Kidz Therapy, PLLC, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury that my child may suffer as a direct result of their participation in the aforementioned Activity.

I agree to indemnify and hold harmless Amazing Kidz Therapy, PLLC against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone else on behalf of my child, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by myself or anyone else on behalf of my child and will be held responsible for any and all financial expenses incurred by Amazing Kidz Therapy, PLLC.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written construed and enforced as so limited.

Childs Name: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Relationship to Child: _____