



Amazing Kidz

Therapy, PLLC

Social Skills Group Enrollment Form

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

Parent/Guardian:	
Relationship to Child:	
Please provide your best contact phone numbers:	
Cell #:	Home/Other #:
Mailing Address:	
Email Address:	

Parent/Guardian:	
Relationship to Child:	
Please provide your best contact phone numbers:	
Cell #:	Home/Other #:
Mailing Address:	
Email Address:	

Emergency Contacts

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

Name:	Phone:
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 Liberty Bell Stables to best meet the needs of my child. 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, with the following organizations, practices and individuals:

Financial Responsibility

All payment for the group is due prior to the commencement of the group starting as per the payment plan as stated my confirmation letter. Refunds will not be provided should my child miss a session throughout the group.

Parent/Guardian Signature: _____ Date: _____

Medical History

Diagnoses

Please list all diagnoses that have been given to your child and 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? Yes No

Does your child have any low vision difficulties? Yes No

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