Handwriting Support 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: _______

Financial Responsibility

Payment for the group is due in full or in 3 lump payments beginning at the start of the group. Refunds will not be provided should my child miss a session throughout the group. In addition, should my child choose to leave the group prior to its conclusion all undue balances will be billed to me.

Parent/Guardian Signature: ____ Date: _______

Brief Medical History

Diagnoses

Please list any diagnoses that you feel will be helpful to have knowledge of for the purpose of these support gropus.

____
____
____
____
____

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):

____
____
____