

THErapy SOLUTIONS FOR KIDS

5200 SW Macadam Suite 100
Portland, OR 97239

Phone: 503-224-1998
FAX: 503-224-5176

Please fill out form and return it to Therapy Solutions for Kids as soon as possible.

Date: _____

Child's Name: _____

Date of Birth: _____ Age: _____

Gender: _____

School: _____ Grade: _____

Does this child receive any special services (e.g., counseling, speech-language therapy, special education)? _____

Parent (s) name (s): _____

Home address: _____

Name of brother or sister with special needs: _____

Date of Birth: _____ Age _____

Gender: _____

Nature of disability, illness or special needs: _____

School: _____

What kind of related special education services (e.g. speech, occupational, or physical therapy, counseling) does this child receive? _____

Other Siblings:

Name

Date of Birth

Age

Gender

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What are your reasons for enrolling your child in the Special Sibs program?

Do you have any concerns about enrolling your child in the Special Sibs?

Do you have any particular topics that you would like addressed during the Special Sibs? _____

Does your child have any allergies or restrictions (food or other) that we should know about? _____

Please provide any other information that you feel will make this an enjoyable and educational experience for your child:

Emergency Contact during Special Sibs Hours:

Name _____ Relation to Child _____

Address _____

Phone Number _____

I assume all risks and hazards of the conduct of the program. In case of injury, I do hereby waive all claims or legal actions, financial or otherwise, against Therapy Solutions for Kids, their elected and appointed officials and employees, the organizers, supervisors, or any volunteer connected with the program. I grant full permission to use any photographs, videotapes, motion pictures, recordings, or any other record of this program for any purpose.

Signature of Parent or Guardian

Date

Please contact Camille at 503-224-1998 ext 127 with any questions.