EMPOWER
PEDIATRIC THERAPY

Enrollment Information Form

Child's full name: _____ Name preferred: _____

Date of Birth: _____ Age: _____ Sex: M / F

Child's Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Child's Home phone: _____ Cell #:_____ Work #:_____

Email for Tuition Statements: _____

How did you hear of us? _____

Parent's Name _____

Address (if different than child's) _____

Employer: _____

Work Phone # ( ) _____ Cell No. ( )_____

Parent's Name _____

Address (if different than child's) _____

Employer: _____

Work Phone # ( ) _____ Cell No. ( )_____

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Emergency Contact (in case parent/guardian is not reachable):

Name _____ Phone # ( ) _____

Relationship _____ other # ( ) _____

Address _____ City _____ State _____ Zip Code _____

Other Person(s) authorized to pick up my child from Empower Pediatric Therapy and receive related information.

Name _____ Phone # ( ) _____

Relationship _____ other # ( ) _____

Name _____ Phone # ( ) _____

Relationship _____ other # ( ) _____

Name _____ Phone #( ) _____

Relationship _____ other # ( ) _____

***Note**: A parent or guardian wishing to have someone other than those listed above pick up their child must notify the office in writing or by telephone **prior** to the child's release. Anyone other than the authorized parent or legal guardian, who is designated by the parent or legal guardian, by telephone or note, to pick up a child, will be asked to present identification to a staff member or the child will **not** be released.* Empower Pediatric Therapy will make a photocopy of all persons on authorization list during their first time to pick up child and place in child's file.

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School Activities Permission:

Water Activities: I hereby _____give _____do NOT give my consent for my child to participate in water activities (e.g: sprinklers, water tables, etc).

Program Activities: I hereby _____give _____do NOT give my consent for my child to participate in all planned program activities such as games, gym equipment, face painting, etc.

Publications: I hereby _____give _____do NOT give my consent to Empower Pediatric Therapy for my child's name, address, e-mail, and phone numbers to be given out to other parents and published in the classroom directory.

Pictures: I hereby _____give _____do NOT give my consent for any individual and/or group pictures of my child to be used for education purposes, teacher training or Empower Pediatric use. I understand my child's name or photo will not be used in media for public distribution/at any time without my individual consent.

I/We have completed and understand the enrollment information for my /our child.

_____ _____

Parents' Signature Date

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CONSENT TO TREATMENT OF A MINOR

I/We, the undersigned parent(s)/ Guardian of
_____,

A minor, do hereby authorize Empower Pediatric Therapy, it's therapists', teachers or staff as agent(s) for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and to be rendered under the general or special supervision of any licensed physician and surgeon.

This authorization shall include, but not be limited to, consent for transportation of the minor child by the agent to the hospital or treatment facility should this be expedient or necessary for treatment.

I understand that this authorization is being given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital which the aforementioned physician/surgeon in the exercise of his/her best judgement may deem advisable.

It is understood that the first step taken by the above agent is to contact the parents, if at all possible. It is the parent's responsibility to keep phone numbers, insurance information and doctor's information current.

These authorizations shall become effective as of _____, 20_____.

_____

Signature of Parent/Guardian

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Physician and Insurance Information

Doctor Information:

Physician/Pediatrician (Name and Facility): _____

Physician Phone Number: _____ Physician Fax Number: _____

Insurance Information:

** **Please list insurance information for which the patient is a beneficiary, if you want Empower Pediatric Therapy to file the claim. ****

Policy Holder's Full Name: _____ DOB: _____

Insurance Company Name and Address: _____

Phone: _____ ID# _____ Group# _____

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Patient Needs Assessment

Child's Name: _____ Date of Birth: _____

Birth History

Child was born: _____ full-term or _____ premature; if premature, how many weeks? _____
Delivery: _____ vaginal _____ with forceps _____ C- section
Were there any complications? _____
Was your child placed in the NICU? _____ If so, how long? _____
Please describe any other medical problems or complications at birth.

Development History

Please indicate at what age your child achieved the following milestones:

*Mark N/A for those which your child has not yet achieved.

Rolled over_____ Pulled to stand _____

Babbled_____ Used Spoon _____

Sat alone_____ Stood alone _____

Said first word_____ Toilet Trained _____

Crawled _____ Walked alone _____

Drank from a cup _____ Dressed Self _____

Comments: _____

Medical History

Current diagnosis: _____
Hospitalizations: _____ No _____ Yes
If yes, please describe:
_____
Surgeries: _____ No _____ Yes; If yes, please list _____
_____
Has your child's vision been evaluated? _____No _____Yes; If yes, when and what were the results
_____
Has your child's hearing been evaluated? _____No _____Yes; If yes when and what were the results
_____

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Previous psychological evaluation? _____ No _____ Yes
If yes, please describe
_____
Current Physician(s): _____
Medications: _____
Special equipment your child uses: Splints___ Braces ____ Adaptive Utensils___ Other _____
Any feeding problems or nutritional concerns? _____
Allergies:_____
Medical Precautions:_____

Caregiver Concerns
What are your main concerns about your child?
_____
_____
What are your child's strengths?
_____
_____
Has your child received occupational therapy, physical therapy, or speech therapy before? Y / N
If yes, please indicate which services and for how long: _____

Educational Information
School/Educational Program Currently attending: _____
Present grade level: _____
Special services received in school: _____ OT _____ PT _____ Speech
Does your child receive any of the following?
Special Education_____ Behavior Intervention _____ Other Special service_____
Does your child's teacher have concerns with your child's development in any of the following areas?
Motor Skills ___ Social abilities ___ Self-help skills ___ learning abilities ___
Comments: _____

Social/Emotional Development
Does your child interact well with others? ___ Yes ___ No
Does your child have any trouble making friends? ___ Yes ___ No
Fears, Coping behaviors: _____
Does your child have difficulty calming himself/herself when upset? ___Yes ___ No
Additional comments: _____

Behavior

Please check any of the following that apply to your child:

_____ Cries often

_____Dislikes hair brushing

_____Frequent Temper tantrums

_____Dislikes tooth brushing

_____Anxious

_____Avoids touch from others

_____Trouble following directions

_____Dislikes playground equipment

_____Trouble with change in routine

_____Seems to be "on the go"

_____Clumsy

_____Rocks self

_____Weak muscles

_____Sensitive to light

_____Picky eater

_____Sensitive to sound

_____Mouths objects

_____Poor attention span

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

Signature: _____ Date: _____

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Supplemental Information

This form will remain confidential for the teacher's use and will be used in discussions with parents, speech and language pathologist (if necessary) or occupational therapist in an event the child may need additional assistance. Your answers will provide us with an initial understanding of your child and help make us aware of the concerns that you, as a parent, may have. Please feel free to use the back of this form if you have additional comments, or information that you wish to share regarding your child.

Child's name: _____ Date of Birth: _____

Name you wish us to call your child if different than above: _____

Mother's Occupation: _____ Phone: _____

Father's Occupation: _____ Phone: _____

At Home- The following people live in our home:

Name	Relationship	Age

Does your child have a nanny? _____yes _____no

If yes, the nanny's name is: _____ #years with child: _____

Are there members of the child's extended family with which he/she has a particularly close relationship (e.g., grandparent, aunt, etc.)? _____

Does your child have a pet? _____ Type and Name _____

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Typical Daily Routines (please include the time and usual behavior regarding these routines):

Wakes up: _____
Nap: _____

Bedtime (time and routine leading up to bedtime:

_____

_____

Favorite Activities: _____

Family Activities: _____

Favorite TV shows: _____

Average Daily television time (including weekends):_____

Experience with books: _____

Favorite Stories: _____

Has your child had any major changes in his/her life in the past year which would cause anxiety (e.g., major operations, family changes, accidents)? _____yes _____No

If yes, please describe:

_____

_____

Manner of redirection used in the home and the behaviors which are exhibited by the child which require the parent to use redirection:

_____

_____

How does your child react to the redirection method used in your home?

_____

_____

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Sick Policy

Policy:

It shall be the policy of Empower Pediatric Therapy to abide by the following:

All patients, or parents or guardians of patients, shall telephone to cancel and reschedule appointments when the patient may have one or more symptoms of a contagious disease. This will aid in the protection of the health of the staff, other patients, and family members.

Symptoms:

Fever >100 degrees F
Vomiting / Nausea
Sinus Infection/Cold with yellow or green mucus
Open / Draining Lesion
Lice
Chicken Pox
Measles
Productive cough
Impetigo
Conjunctivitis / pink eye
Strep Throat
Diarrhea
Any Other Contagious Disease Not Listed

I agree to abide by the above stated policy:

Parent / Guardian Signature _____ Date_____

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Payment Awareness Notification

Empower Pediatric Therapy has made me aware that I must pay tuition of $2,500 in full on the first business day of each month. Payments can be made via check or cash. Make checks payable to Empower Pediatric Therapy.

Child's Name:_____

I choose to receive services at Empower Pediatric Therapy and will be responsible for tuition payment on the first business day of each month.

Parent/Guardian Name:_____

Parent/Guardian Signature:_____

Date:_____

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Waiver, Release, and Liability

I, _____

(Guardian) Please Print

Hereby affirm that my child,

_____ (Child's Name)

May participate in all activities at Empower Pediatric Therapy.

I certify that I am aware of the inherent dangers associated with participating in therapy and all activities at Empower Pediatric Therapy

I understand and agree that neither Empower Pediatric Therapy, nor its trustees, representatives, therapists, or agents may be held liable in any way for any occurrence in connection with my child's participating in therapy and activities.

As part of the consideration for participating in therapy, I hereby personally assume all risks in connection with participating in therapy or activities. I further agree to save and hold harmless representatives from any claim by me, or my family, estate, heirs or assignees arising out of Empower Pediatric Therapy to render or obtain such emergency medical care or treatment as may be necessary should any injury, harm, or accident occur while participating in therapy and activities.

I further state that I am of lawful age and legally competent to sign this affirmation and release; that I understand the terms herein are contractual and not a mere recital: and that I have signed this document of my own free act and coalition. I further state and acknowledge that I have fully informed myself of the content of this affirmation and release by reading it before I have signed it.

I have executed this affirmation and release on:

_____ Day of _____, 20_____.

Signature_____

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