Phone: 404-414-7478

lightingthewayot@gmail.com

Permission to Evaluate and Provide Therapy

Please complete the bottom portion of this form to grant permission for *Lighting the Way Pediatric Occupational Therapy Services, LLC* to evaluate your child's occupational therapy skills and provide treatment as needed.

I, _____ authorize Lighting the Way Pediatric Occupational Therapy
(Parent/Guardian)

Services, LLC to evaluate and provide the recommended occupational therapy services to

_____. Treatment/therapy is contingent upon the results of the
(Child's name)

evaluation and the recommendations of the occupational therapist.

I consent to care and treatment that falls within the scope of occupational therapy practices as defined by the State of Georgia. I understand that the practice of medicine, including occupational therapy, is not an exact science and the treatment will involve physical participation on the part of the client which may involve risks of injury. I feel the possible benefits to myself, son/daughter, ward are greater than the risks assumed. I hereby, intending to be legally bound for myself, son/daughter, ward waive release forever all claims for damages against *Lighting the Way Pediatric Occupational Therapy services, LLC,* its therapists, aides, volunteers and employees for any and all injuries and loses including theft, loss of property or death that I, my son/daughter or ward may sustain while participating in *Lighting the Way Pediatric Occupational Therapy services, LLC* program. By signing this form, I acknowledge that I have read and understand the contents and am competent to execute it or if executed on behalf of another, that I am authorized to execute it on behalf of that person.

_____ _____
Parent/Guardian Signature Print name of parent/guardian

_____
Date