SPECTRUM PEDIATRICS THERAPEUTIC PLAYGROUP REGISTRATION

Child's Name: _____ Date of Birth: _____

Gender (check one): ☐ Male ☐ Female

FAMILY INFORMATION

Parent/Guardian 1: _____ Relationship to Child: _____

Address: _____
Street City State Zip

Phone: (____) ____–____ (____) ____–____ (____) ____–____ Email: _____
Home Cell Work

Parent/Guardian 2: _____ Relationship to Child: _____

Address: _____
Street City State Zip

Phone: (____) ____–____ (____) ____–____ (____) ____–____ Email: _____
Home Cell Work

SESSION REGISTRATION

Each session will be 6 weeks long. Enrollment fee covers participation in one playgroup for the entire 7 week session. ENROLLMENT DEADLINE: June 28, 2013 (will accept on a rolling basis after deadline). Payment plan options are available. A non-refundable deposit of $150 per playgroup will be due with enrollment application. (Deposit will be applied to the overall program fee.)

_____ 1. PLAYFUL PANDAS (5 and younger) Tuesdays, July 9 - August 13, 2013 (9:00 am - 11:00 am) $900

_____ 2. MOVING MONKEYS (5 and older): Tuesdays, July 9 - August 13, 2013 (1:00 pm - 3:00 pm) $900

_____ 3. WRITING WARRIORS: FUN WITH FINE MOTOR (Kindergarten and older): $900
Wednesdays, July 10 - August 14, 2013 (1:00 pm - 3:00 pm)

_____ 4. TODDLER TALK: Fridays, July 12- August 16 2013 (9:30 am—10:30 am) $450

MEDICAL INFORMATION

Physician's Name: _____ Phone: (____) ____–____

Address: _____
Street City State Zip

Emergency Contact, if parent is not reachable: _____ Relationship to Child: _____

Phone: (____) ____–____ (____) ____–____ (____) ____–____
Home Cell Work

Does your child have any diagnosed medical conditions? ☐ Yes ☐ No

If Yes, Please describe: _____

_____

Any previous medical conditions or surgeries? ☐ Yes ☐ No
If Yes, Please describe: _____

_____

Is your child taking any medication? ☐ Yes ☐ No

Medication Dosage Frequency

_____

_____

Allergies (check all that apply): ☐ None ☐ Food ☐ Medicine ☐ Environment

Please describe the allergy and reaction seen: _____

_____

Special Dietary Guidelines: _____

_____

_____

PARENT COMMENTS

Please describe any additional concerns/information you may have about your child at this time: _____

_____

_____

IMPORTANT—THIS BOX MUST BE COMPLETE FOR CHILD TO PARTICIPATE

Parent/Guardian Authorization: This health history is correct and accurately reflects the health status of the child to whom it pertains. The person described has permission to participate in all program activities. If I cannot be reached in an emergency, I give permission to a physician/hospital to order x-rays, tests, and provide treatment related to the health of my child. I understand the information on this form will be shared on a "need to know"basis with Spectrum Pediatrics staff. I give permission to photocopy this form. In case of chronic or serious conditions, Spectrum Pediatrics has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with Spectrum Pediatrics staff about my child's health status.

Parent/Guardian: _____ Relationship to child: _____

Signature: _____ Date: _____

SERVICE AGREEMENT

Enrollment deadline: June 28, 2013 (will accept on a rolling basis after deadline). A $150 non-refundable deposit is required to reserve a spot for your child. Deposit will be applied towards the overall tuition cost.

Payment Options:

☐ Pay in full, a check is enclosed for $ _____ or bill credit card (see below).

☐ Pay for half, a check is enclosed for $ _____ or bill credit card (see below).
The remainder is due by July 19, 2013 (we will charge your credit card on this date if you choose to pay by credit card).

Please charge by Visa, Mastercard, Discover or American Express (circle one) $_____.

Card Number_____ Exp. Date ____/____ CVV:_____ Zip Code:_____

Signature:_____

I have enclosed a completed registration form for my child. I understand that all program activities are conducted by qualified personnel in a safe acceptable manner. I understand that I will receive a treatment note at the end of each session with the appropriate procedure and diagnosis codes. Please initial: _____

RELEASE OF LIABILITY CLAUSE

I hereby expressly waive any claim of liability against Spectrum Pediatrics including its employees and representatives, and release them from all liability in connection with the program activities.

Parent/Guardian: _____ Relationship to child: _____

Signature: _____ Date: _____

PHOTO RELEASE

I give permission for Spectrum Pediatrics to use photographs of my child for any lawful purpose including treatment sessions, publicity, illustration, advertising and web content.

Photo Release (check one): ☐ Yes ☐ No Please initial: _____

ADDITIONAL INFORMATION:

Spectrum Pediatrics
C/O Registration
2869 Duke Street
Alexandria, VA 22314

spectrum pediatrics