Consent for Release of Information

Client Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone #: _____

Address: _____ Cell #: _____

City/State/Zip: _____ Work #: _____

Primary Care Provider Name and #: _____

I authorize The Therapy Tree, LLC to release and/or obtain information to/and/or from:

_____ _____

_____ _____

_____ _____

Specific information/reports requested:

___ Developmental Reports ___ OT/PT Reports ___ Vision Evaluation Reports

___ Speech/Language Reports ___ Audiological Reports ___ IFSP/IEP

___ Medical Reports ___ Other: _____

The information is needed for the following purpose(s):

___ IFSP/IEP Development/Planning ___ Treatment Planning ___ Team Collaboration

___ Other: _____

The consent is valid until discharge of service or upon written revocation of parent/legal guardian, whichever date is sooner.

_____

Printed Name of Client/Guardian

_____ _____

Client/Guardian Signature Date Signed

The Therapy Tree, LLC | 89 Cedar Ave. P.O. Box 764 Lake Villa, IL 60046
ph (847) 265-7300 fax (847) 265-7301
"Growing Together in Mind and Body"
www.thetherapytree.org

Consent for Touching and Holding

Child's Name: _____

During the course of therapy, your child may need to be touched or held (contained). You will be present whenever your child is touched or held. If at any point in the course of therapy you do not think that such physical contact with your child is in his/her best interest, please inform your therapist. Holding or touching your child is done for various therapeutic reasons including:

1. Helping your child to relax.
2. Containing or regulating anxiety.
3. Helping your child to focus.
4. Helping your child to feel empathy and understanding for any distress.

If your child has difficulty dealing with stress or frustrations and often responds with tantrums, rage, or out-of-control actions, then it is possible that any stress occurring in therapy will elicit similar reactions. Perhaps at this time we will also hold or touch your child, or may ask you to do so, for the purpose of regulating the anxiety your child is experiencing. Containment may occur at those times.

1. Only when it can be done guaranteeing physical safety to your child.
2. Only with empathy and understanding.
3. Only as long as necessary for the child to re-establish self-regulation.
4. Only with your permission.
5. Only for the purposes of containing anxiety.

You may withdraw your consent at any time.

_____

Printed Name of Client/Guardian

_____ _____

Client/Guardian Signature Date Signed

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Photographic and Video Consent

Child's Name: _____

____ I give my permission for my child's picture / video to be used by The Therapy Tree for the purpose of training his/her specific clinical team.

____ I give my permission for my child's picture / video to be used by The Therapy Tree for the purposes of training other professionals or paraprofessionals.

____ I give my permission for my child's picture / video to be used by The Therapy Tree informational literature.

____ I do not wish my child to be videotaped or his / her picture taken.

_____
Printed Name of Client/Guardian

_____ _____
Client/Guardian Signature Date Signed

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Food Permission/Dietary Information

Child's Name: _____

Please complete the following to inform the Kids Therapy staff of your child's diet restrictions and to allow your child to participate in snack activities.

____ My child may participate in snack time and has no diet restrictions.

____ My child may participate in snack time if diet restrictions are observed.

Please list diet restrictions below.

____ My child may participate in snack time; however, I will provide his/her snack.

____ My child should not participate in snack time.

Please list food allergies or restrictions for your child:

_____ _____

_____ _____

_____ _____

_____ _____

Please list the food(s) your child is motivated to eat:

_____ _____

_____ _____

_____ _____

_____ _____

_____

Printed Name of Client/Guardian

_____ _____

Client/Guardian Signature Date Signed

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