



141 N Main Street
Fuquay-Varina, NC 27526

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www.capitolcityspeechtherapy.com

Permission Form Five Senses Camp 2019

Monday - Friday
Ages 3-5
June 24th – 28th
\$150 +\$15 registration

I _____ give permission for my child _____
(Name of Parent or Legal Representative) (Name of Client Being Treated)
to attend Capitol City Speech Therapy's "Five Senses Camp" program (Fuquay Varina only). I understand that my child will be working with other children, volunteers and other family members, who may be observing and/or assisting with the class.

I agree to pay for Summer Camp in advance. Payments can be made by cash, check or charge. I understand that Registration is non-refundable and will be used to reserve a "slot" for my child in the program. Tuition is due on or before June 10th. The Fuquay Varina office will be responsible for accepting payments. I also understand that if sessions are missed due to client cancelations, there will be no refunds. I also understand that my insurance will NOT be billed for the Summer Camp tuition or registration.

MEDICAL AUTHORIZATION:

_____(initial) I agree that Capitol City Speech Therapy staff may administer first aid, perform CPR and authorize a physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately. I understand that all medical costs incurred are my responsibility. I release and forever discharge Capitol City Speech Therapy, LLC and the owners, contractors, agents, and employees from and against any and all liability incurred as a result of any act they may perform on behalf of my child (CPR, for example).

PHOTO RELEASE:

_____(initial) I DO I DO NOT give express permission for Capitol City Speech Therapy to exhibit photographs, and videos of _____ (name of student). Images may be used on Capitol City Speech Therapy website, group facebook page (secure) and/or other publications. I understand that this permission cannot be revoked.

THERAPY DOG:

_____ (initial) I DO I DO NOT give permission to Capitol City Speech Therapy to have a therapy dog “in training” in the classroom/gym and/or therapy sessions with my child,

AUTHORIZATION FOR PICK UP:

I hereby give permission for the following person(s) to pick up my child from Capitol City Speech Therapy Preschool/Camp/Group services.

Name of Approved Person(s):

_____/_____
Name Relationship

_____/_____
Name Relationship

_____/_____
Name Relationship

_____/_____
Name Relationship

I understand that a photo ID will be required for my child to be picked up from Capitol City Speech Therapy.

_____ June Rate: \$150 M-F, 9am-12pm ages 3-5 - (max 12)

By signing this form, it indicates that I have **read** and **fully understand** the terms listed above.

_____/_____/_____
Signature of Client / Legal Representative **Relationship** **Date**