Capitol City
Speech Therapy, LLC

141 N Main Street
Fuquay-Varina, NC 27526

1520 Glenwood Avenue, Suite 201
Raleigh, NC 27608

Office: 919-577-6807 Fax: 919-577-6853
www.capitolcityspeechtherapy.com

Permission to participate/payment terms

August 2018

"Lego Camp Part 2"

August 6-10 Monday-Friday
12:30-3PM

I ________________________________give permission for my child _______________________
(Name of Legal Representative or Client) (Name of Client Being Treated)

to attend Capitol City Speech Therapy's "Power Packed Vocabulary" 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 July 27. 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 (circle one) 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.

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.

______July Rate: $150 Monday-Friday ages 4-9 (max 6)

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

______________________________________/___________________/________________
Signature of Client / Legal Representative Relationship Date