SANDCASTLE
Clinical & Educational Services

LA HEARING CENTER

THERAPY PERMISSION FORM

Client name: _____ Date of birth: _____

Please read and initial each item. Thank you.

_____ I give permission for Sandcastle to enroll my child in a therapy program.

_____ I understand that I must notify Sandcastle prior to the appointment time if my child is unable to attend a scheduled therapy session.

_____ I understand that under special circumstances make up sessions may be arranged for missed therapy sessions. However, this arrangement is not always possible due to scheduling commitments.

_____ I am aware that observations or participation in therapy session is supported and encouraged.

_____ I give permission for individuals involved in my child's program to observe my child's therapy session.

_____ I give permission for my child to be seen by an alternate provider in the event that the regular treating provider is absent.

_____ I understand that if my child has excessive absences I will be notified about the discharge of my child from therapy.

_____ _____

Signature of Parent or Guardian Date