Pediatric Therapy Services

GROUP REGISTRATION FORM

Date: _____

Patient's Name: _____

Diagnosis: _____

❑ Female ❑ Male Patient's DOB: _____

Home phone number: _____

Parent/Guardian Name: _____

Mother Wk # or cell #: _____

Father Wk# or cell #: _____

Address: _____

City/State/Zip: _____

E-Mail: _____

Payment Amount: _____

Check #: _____

Owed: _____

Emergency Contact: _____

Relationship: _____ **Phone #** _____

Please check which therapy group your child will be attending:

- ❑ Handwriting / 6 weeks
- ❑ Social skills / 6 weeks

***Parent must obtain prescription or physical form from doctor for any of these starred group sessions:**

- ❑ Feeding Group *
- ❑ Bike Riding clinic / 6 weeks *
- ❑ Motor Coordination / 6 weeks *
- ❑ Sensory Integration *

How did you hear of us? _____

I authorize my child to participate in group therapy.

_____

Signature Date

Return to: Kids In Motion • 2636 S. Milford Rd. Highland, MI 48357
(248) 684-9610 • Fax (248) 684-9611 • kidsinmotion@kidsinmotionmi.com