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: **(If not a current patient starred groups require note from doctor approving physical activity.)**

- ❑ Handwriting (6 weeks)
- ❑ Social skills (6 weeks)
- ❑ Feeding Group*
- ❑ Bike Riding clinic (6 weeks)*
- ❑ Motor Coordination (6 weeks)*
- ❑ Sensory Integration*

Prescription/physical form from doctor says approved for physical activity: _____

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