

## Parental Release (Please complete and return)

**Student Name:** \_\_\_\_\_ **Child's School:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Business Name:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Relationship to Student:** \_\_\_\_\_

**Student Information:** Needs an orthopedic device? Y\_\_N\_\_ If so, type \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Verbal?** Y\_\_N\_\_ If no, uses sign language or other means to communicate? \_\_\_ Please explain \_\_\_\_\_

**What is the approximate age level of social skills?** \_\_\_\_\_ **Self help skills?** \_\_\_\_\_

**Student's Diagnosis:** \_\_\_\_\_

Please list any medications and dosage:


**Allergies:** \_\_\_\_\_

**Primary Physician:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Practice Name:** \_\_\_\_\_

Please check any of the following that pertain to the student:

<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Tantrums
<input type="checkbox"/>	Aggressive behavior towards others	<input type="checkbox"/>	When angry attempts injury
<input type="checkbox"/>	Habits/tics	<input type="checkbox"/>	Learning differences (ADD etc.)
<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	has Fears (loud noises etc.)
<input type="checkbox"/>	Sexual acting out	<input type="checkbox"/>	Startles

Please explain any items checked:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does he/she have siblings? \_\_\_\_\_ Age (s) \_\_\_\_\_

How is the relationship with their siblings? \_\_\_\_\_

How does the student interact with other children? \_\_\_\_\_

How does the student interact with teachers/other adults? \_\_\_\_\_

Other behaviors: \_\_\_\_\_

**Health and Helping Professionals-** Please fill those that apply.

<b>Occupational Therapist:</b>
<b>Telephone:</b>
<b>Address:</b>
<b>City:</b>
<b>Zip:</b>
<b>Practice Name:</b>

<b>Physical Therapist:</b>
<b>Telephone:</b>
<b>Address:</b>
<b>City:</b>
<b>Zip:</b>
<b>Practice Name:</b>

<b>Speech Therapist</b>
<b>Telephone:</b>
<b>Address:</b>
<b>City:</b>
<b>Zip:</b>
<b>Practice Name:</b>

<b>Neurologist:</b>
<b>Telephone:</b>
<b>Address:</b>
<b>City:</b>
<b>Zip:</b>
<b>Practice Name:</b>

<b>Social Worker/Case Manager:</b>
<b>Telephone:</b>
<b>Address:</b>
<b>City:</b>
<b>Zip:</b>
<b>Group Home:</b>

Child's caregiver/nurse/CAP worker's name: \_\_\_\_\_

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Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

Will this person bring child to class? \_\_\_\_\_

**Class Policies**

1. The Foundation considers itself to be in a "helping profession." Our goal is always to provide our student with the best and most appropriate movement education program for their level of ability. The Foundation is the final decision-making authority with the regard to the curriculum and direction of all Foundation classes and programs.
2. All applications, medical history, and release forms must be completed and on file prior to the start of class.
3. When a student's behavior disrupts a class, the parents will be notified verbally and/or in writing. If disruptive behavior occurs on three occasions within two months, the student will be asked to leave the program. Should parents or guardians wish to appeal the decision, they may do so by asking for reconsideration by the evaluating committee.
4. Teaching movement education classes requires some physical contact and touching of students to demonstrate positions. Students with difficulties in this regard may not be candidates for our program and parents should consider their decision carefully to avoid dismissal from the program at a later date.
5. Each student must have bladder and bowel control or wear suitable undergarments. Students must be toileted before class.

**Release of Information**  
**(Please check items you give permission for)**

I \_\_\_\_\_ give permission for

Yes/ No

- My child's school, teachers and support staff to share current IEP, IFSP or 504 Plan with Allegro Foundation for the purpose of assessment and evaluation.
- Allegro Foundation to share my child's IEP, IFSP, or 504 Plan; medical and personal records with Allegro's Medical Director and Assessment/Evaluation team for purposes of evaluation only.
- Allegro Foundation to test my child twice a year with the Allegro Foundation assessment and evaluation PF scale outlined in the parent packet of information.

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**Photo/Video Release**

Yes/No

- I hereby give Allegro Foundation...a Champion for Children with Disabilities the absolute and irrevocable right and permission to use photographs and/or videos of Foundation classes or programs in which my child might appear in for the use in Advertising, public relations, or promotional purposes and/ or Demo tapes submitted with grant applications.

**I/we further grant the Foundation permission:**

- To copyright the same in their own name or any other they may choose.
- To use, re-use, publish and re-publish the same in whole or in any medium, for any purpose whatsoever, including (but not limited to) the uses listed above.
- To use my name in connection therewith if they so choose.

I hereby release and discharge Allegro Foundation from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees and assigns of Allegro Foundation as well as the person/persons for whom they took the photographs or video.

**I have reviewed and understand the policies of the Allegro Foundation as described above and agree to abide by them.**

I have read and understand the above statements and release the Allegro Foundation...a Champion for Children with Disabilities, its Board, staff and volunteers, from responsibility for the medical care and treatment of my child, except in cases of emergency as described above.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date