Autism Movement Therapy

Susan Ojala Myers S.O.M.E. Productions

Name of Student ______________________________

Name of Parent/Guardian ______________________________

Address ______________________________

Number, Street, and Apartment

____

City State Zip

Phone ______________ Email ______________

Is there a formal diagnosis? ______________________________

Is the student verbal? ______________________________

How are group settings tolerated? ______________________________

Is there any aversion to physical contact? ______________________________

Are there any behavior issue or concerns? ______________________________

If so, please describe triggers. ______________________________

Does the student have any physical limitations? ______________________________

How well does the student handle direction? ______________________________

Is the student in an inclusive, or special day program? ______________________________

Any other comments/concerns: ______________________________

____

____

As the legal parent or guardian, I release and hold harmless Susan Ojala Myers and S.O.M.E. Productions from any and all liability, claims, demands, and causes of action whatsoever, arising out of or related to any loss, damage, or injury, including death, that may be sustained by the participant and/or the undersigned, while participating in any activity under the control and supervision of Susan Ojala Myers and Some Productions or in route to or from any of said activity.

Date ____________ Signature ______________________________