Registration form for Autism Movement Therapy

Name of Child: Age of Child:
Name of Parent or Care Provider:
Phone number:
Email Address:
Signature of Person enrolling Participant: _____

Questionnaire:
1. Does your child have any physical limitations? _____
2. Does your child have seizures? _____
3. Does your child have a cardiac problem? _____
4. Can you think of any reason, such as recent physical illness or chronic condition that might hinder their ability to participate safely in Autism Movement Therapy?

_____

You will be contacted if your child has been selected to participate in the 6 week session once the registration form and questionnaire has been received. Thank you for your interest in this program!

I understand that this 4 week session of Autism Movement Therapy is presented with an emphasis on safety, non-competition & mindfulness, and have explained this to my child, who promises herein to practice mindful movement and to avoid forcing his/her body in any way in the classes. My child is participating voluntarily in this Autism Movement Therapy and is physically able to proceed with this program. With this questionnaire/registration form I am informing the instructor of any physical limitations and/or health concerns, for which I accept sole responsibility. Additionally, I hold harmless Kristy Cox, Saratoga Core Fitness, for any liability for any personal injuries or loss of my personal property or third party claims by reason of participation in this program. I waive the rights to claims for any damages/injuries against Kristy Cox, Saratoga Core Fitness and third parties. Also, I understand the course fee is inclusive, and once I register no refunds will be given for classes I do not attend. I have written my email address legibly here so I may be notified of any changes in the schedule.

In signing I acknowledge I have read, understand and agree to the terms detailed here in this "Assumption of Risk" waiver.

Signature of Parent /Guardian's Signature_____