



CONSENT FOR TREATMENT FORM

Child's Name: _____

I give permission for the staff occupational/speech therapists at Cowtown Pediatrix Clinic (CPC) to evaluate and treat my child. When OT/ST interns are rotating through CPC, I understand that my child may be evaluated and treated by an OT/ST intern. I understand that my child's clinical needs will always be under the supervision of a licensed OTR/SLP from CPC. I also understand that the level of independence the OT/ST intern has with my child is directly related to his/her level of clinical development within his/her fieldwork experience. In addition, I understand, while CPC strives to be consistent, that due to availability in the schedule, the therapist that performs the evaluation may not necessarily be my child's ongoing therapist.

Parent/Guardian Signature

Date

I understand that all information surrounding my child is private and confidential. I also give permission for email correspondence with CPC regarding my child.

Parent/Guardian Signature

Date

I authorize CPC to discuss my child's care, if applicable, with other team members, such as doctors, school, speech therapist, etc.

Parent/Guardian Signature

Date

I authorize CPC to use my child's photo(s) in our brochures, printed materials and in the Clinic, and my child's photo(s) and/or videos on our website for the use of public promoting various occupational therapy programs. I understand that I will be notified before the use of the photo(s) and/or video(s).

Parent/Guardian Signature

Date