Positively Playful Occupational Therapy, PLLC

Registration and Release Form

Client Name_____ Date of Birth_____ Gender:_____

Name of Parent/Guardian_____

Home Address_____ City_____ State___Zip Code_____

Home Phone_____ Cell phone_____ E-mail_____

Emergency Contact_____ Phone Number_____ Alt. Number_____

MEDICAL INFORMATION

Diagnosis_____ Date of Onset_____

Primary Care Physician_____ Phone_____

Referring Physician (if different)_____ Phone_____

Current therapy services_____

Current height_____ Current Weight_____

Allergies_____

Has patient ever been diagnosed with the following (check all that apply):

__seizures	__diabetes	__high blood pressure
__migraines	__heart problems	__kidney or liver dysfunction
__cancer	__arthritis	__stroke or vascular problems
__asthma	__allergies	

Please explain_____

PHOTO/VIDEO RELEASE

____I hereby consent to and authorize _____I do not consent to nor do I authorize

the use and reproduction by Positively Playful Occupational Therapy, PLLC, of any and all photographs and any other audiovisual materials taken of me and/or my child for promotional printed material, promotional website material, educational activities, exhibitions or for any other use to benefit the program

Signature of client (or legal guardian)_____ Date_____