



**Parental Consent Form**

**\* Form must be completed in its entirety or will not be accepted**

Member Name: \_\_\_\_\_

Member RID #: \_\_\_\_\_

Member Diagnosis: \_\_\_\_\_

I (print name of parent/legal guardian) \_\_\_\_\_  
hereby authorize (print name of provider) \_\_\_\_\_  
to evaluate, as well as provide any subsequent treatment based on the evaluation results for (please check all services  
that apply) \_\_\_\_\_ Physical Therapy, \_\_\_\_\_ Occupational Therapy and/or \_\_\_\_\_ Speech Therapy for child named  
above.

\_\_\_\_\_  
Signature of Parent/Legal Guardian if a minor

\_\_\_\_\_  
Date Signed by Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Member

A handwritten signature in black ink, appearing to read "Theresa Edmondson".

\_\_\_\_\_  
Signature of Therapist or Representative of Therapy Group

\_\_\_\_\_  
Date Signed by Provider