# Handwriting Group
## September 18 - October 23, 2019
## 5PM-6PM

Our Handwriting Group is for kids between the ages of 5-10. It will help improve writing legibility, address issues with letter reversals, and develop skills beneficial for learning. We will be using the Handwriting Without Tears workbooks. which was developed by occupational therapists. To lay the foundation for good handwriting, each day we will incorporate sensory motor activities that work on the proprioceptive, vestibular, tactile and visual systems as well as activities to improve fine motor and visual motor skills. The group is limited to 6 participants. This is a 6 week program and to receive the full benefits of the program, participants need to attend each week.

Prerequisites
Your child must be able to do the following:

- Sit at a table and attend to a task
- Can write and identify all letters of the alphabet
- Be able to participate in age appropriate classes
- Follow activities without direct one on one supervision

Cost
$330 for 6 week program
$100 non-refundable deposit is required to secure a place. The balance is due on September 2nd.

Materials
Please provide a current sample of your child's handwriting so we can determine their level. A scanned copy or photo can be emailed to office@solarispediatrictherapy.com.

Registration info:

| Child's name: | |
|---|---|
| Child's DOB: | |
| Child's grade: | |

| Parent's name: | |
|---|---|
| Parent's number: | |
| Parent's email: | |
| Address: | |

Please list any allergies, medications or health concerns:

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|---|
| |

Please list your handwriting concerns/goals:

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Pick Up Authorization

Please list the name, relationship (family member, friend, sitter, etc.) and phone number of all adults who have your permission to pick up your child from the group. Parent's names do NOT need to be listed.

| Name: | | |
|---|---|---|
| Relation: | | |
| Phone: | | |

Medical Release

In the event that we cannot be reached to make arrangements for Emergency Medical Attention for our child/children, we hereby authorize representatives of Solaris Pediatric Therapy to give consent for any and all necessary emergency medical care. In consideration of this necessary emergency medical care, I agree to hold Solaris Pediatric Therapy, its employees, members, and volunteers free from any liability for any injuries my child may sustain while being treated in accordance with said medical release. If required, I instruct Solaris Pediatric Therapy to inform emergency medical staff to transport my child/children to (insert name of hospital). In the absence of a preference, your child will be taken to the nearest hospital or minor emergency clinic.

Parent / Legal Guardian Signature Date

Child's PCP: Phone:

Media Release

I agree to allow Solaris Pediatric Therapy to photograph/ video my child/children for educational and promotional purposes. I understand that these photos/ videos may be used for public viewing. I understand that my consent may be withdrawn in writing at any time.

______________________________________________________________________________

Parent / Legal Guardian Signature                                                                                    Date

If your child is not a previous or current client, please indicate how you heard about us:

______________________________________________________________________________

Please select the amount you would like to pay. You may pay by check, cash or credit card. Credit card payments can be taken over the phone.

☐ Deposit                    ☐ Full balance

Please make checks payable to Solaris Pediatric Therapy. Write the name of your child on the check. Checks may be mailed to PO Box 66701, Houston, TX 77266 or left with our office manager, Allyson Alli. Payments are non refundable.

**Questions?**     office@solarispediatrictherapy.com     832-727-3771