

**Summer 2023 Programs - Registration Form**

Please forward forms via fax (305) 936-1022 or email to [info@mailppa.com](mailto:info@mailppa.com)

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent(s)/Caregiver(s) Name: \_\_\_\_\_

Parent(s) Phone Contact Information: \_\_\_\_\_

Parent(s) Email Address(es): \_\_\_\_\_

Emergency Contact-Name and Phone #: \_\_\_\_\_

School and Grade Child Attends: \_\_\_\_\_

Home Address, City, State and Zip: \_\_\_\_\_

Individuals authorized to pick up your child: \_\_\_\_\_

Are you a new patient/family to our practice?:  Yes  No

**Please CHECK the box for the program your child will be attending:**

**Intensive Social Skills Programs:**

Ages 7 to 10 > 9 am - 12 pm

Ages 11 to 14 > 1 pm - 4 pm

\*Minimum 4 participants to run program.

**Aventura**

June 12-16

**South Miami**

June 19-23

August 7-11

**Weston**

June 26-30

July 17-21

**High School Life Skills:**

Entering Grades 9-12 > 10 am - 12 pm

\*Minimum 4 participants to run program.

June 26-30 **South Miami Location only**

## Summer 2023 Programs - Registration Form (page 2)

**Child's Name:** \_\_\_\_\_

Does your child have any dietary restrictions (allergies, kosher, gluten-free)? If so, please list: \_\_\_\_\_

Please list any goals/expectations you may have for your child's camp experience: \_\_\_\_\_

What activities does your child enjoy doing? \_\_\_\_\_

Please tell us anything else that would be important for us to know about your child: \_\_\_\_\_

### *Consent for Summer Programs*

I voluntarily give consent for treatment by *Pediatric Psychology Associates* for myself and/or my family members. I understand the purpose is to assist in the formation and development of improved social skills and emotional health. I can withdraw my consent at any time without penalty to me or my child.

I understand that summer programs may be taped for the purpose of ongoing assessment and training of group participants. *Pediatric Psychology Associates* will not release confidential material to other outside parties without written permission. As provided by law, confidentiality may only be breached for protection purposes when the patient is imminently dangerous to her/himself or others, or in cases of child abuse.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Relation to child** \_\_\_\_\_

### *Photograph and Videotape/Media Release Consent Form*

The following is a Consent Agreement, which authorizes the videotaping, photographing and social media release of videotapes and photographs taken during Pediatric Psychology Associates' Summer Programs. Pediatric Psychology Associates may photograph and/or videotape participants during their participation at Pediatric Psychology Associates' Summer Programs. These videos and photographs may be posted on social media for the purpose of educating the public with regards to recreational services available to children with social challenges. Please initial an option below and sign at the bottom of this page.

\_\_\_\_\_ Yes, my child's photographs/video may be released for use in social media. I understand that I am free to withdraw my consent at any time without penalty to me or my child.

\_\_\_\_\_ No, my child's photographs/video may not be released for use in social media.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Relation to child** \_\_\_\_\_

## Summer 2023 Programs - Registration Form (page 3)

**Child's Name:** \_\_\_\_\_

**Fees and Payment Options for Summer Programs:**

\$1000 per program

*\*If child is not a patient of PPA, all programs include a phone screening and, if needed a no-cost 15-minute video or in-person consultation to determine appropriateness of fit.*

*Please note paperwork must be completed in order to secure your child's spot in our programs.*

**All summer program fees are due fourteen (14) days prior to the start date of the program\***

In order to provide adequate staffing and preparations, please note that cancellation less than 7 days prior to program/camp and no show or missed days will not be refunded.

**Please initial one:**

\_\_\_\_\_ I will pay \$1000 by cash or check (payment must be received on or before 14 days prior to the first day of my child's scheduled program).

\_\_\_\_\_ I will pay \$1000 by credit card (credit card will be charged 14 days prior to the first day of my child's scheduled program).

Below is my credit card information. This option is recommended.

Name on Card \_\_\_\_\_

I authorize *Pediatric Psychology Associates* to charge my credit card as follows:

Type of Card:    Visa    MasterCard    AMEX   Expiration Date \_\_\_\_\_

Credit Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_, CVV Number \_\_\_\_\_ a 3 or 4-digit number in reverse italics on the **back** of the credit card

Card Holder's Billing Address for Credit Card Statements

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PLEASE SIGN-** Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Print Name and Relationship to Camper:** \_\_\_\_\_