



Aventura ● Weston ● South Miami
Miami-Dade (305) 936-1002
Broward (954) 753-1112
Fax (305) 936-1002

Summer 2024 Programs - Registration Form

Please forward forms via fax (305) 936-1022 or email to groups@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

July 29-August 2

South Miami

July 15-19

August 5-9

Weston

June 24-28

July 22-26

High School Life Skills:

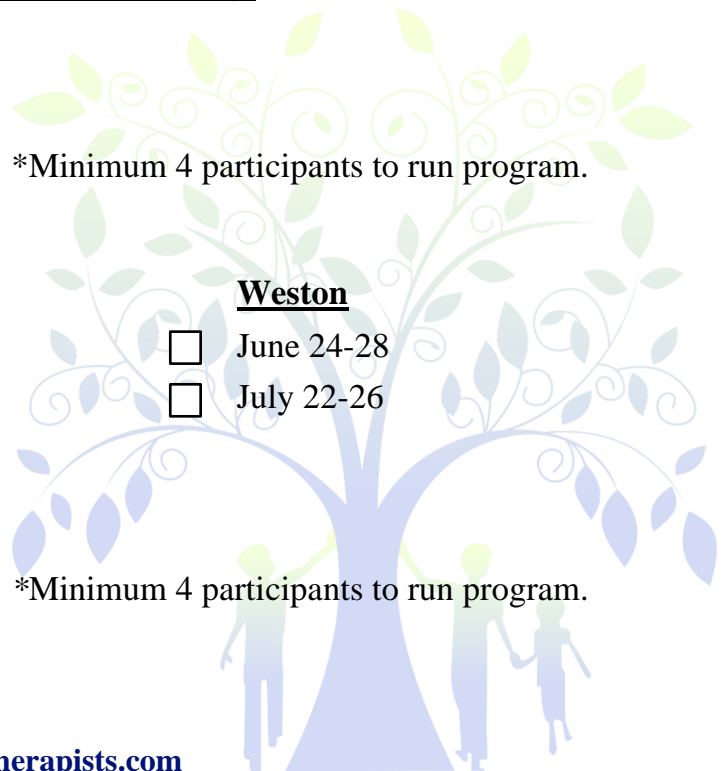
Entering Grades 9-12 > 10 am – 12 pm

*Minimum 4 participants to run program.

June 24-28 **South Miami Location only**

www.SouthFloridaTherapists.com

Mailing Address: 2925 Aventura Boulevard, Suite 300, Aventura, FL 33180





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Summer 2024 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** _____

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Summer 2024 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: _____

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