Parental Release

(Please complete and return)

Student Name:_____Child's School: _____

Parent/Guardian: _____

Address:_____City:_____State:_____Zip:_____

Home:_____Cell: _____

E-mail:_____

Company You Work For: _____
Work Telephone:_____

Emergency Contact:_____Telephone:_____
Relationship to Student: _____

Student Information: Needs an orthopedic device? Y__N__If so, type_____
Birth Date:_____Age:_____ Verbal? Y__N__If no, uses sign language or other means to communicate?____Please explain_____
What is the approximate age level of social skills?_____Self help skills? _____
Student's Diagnosis:

_____

Please list any medications and dosage:

Allergies:_____

Primary Physician: _____
Telephone: _____
Address:_____
City:_____**Zip:**_____
Practice Name: _____

Please check any of the following that pertain to the student:

	Seizures		Tantrums
	Aggressive behavior towards others		When angry attempts injury
	Habits/tics		Learning differences (ADD etc.)
	Mood Swings		has Fears (loud noises etc.)
	Sexual acting out		Startles

Please explain any items checked:

_____
_____
_____
_____
_____

Does he/she have siblings?_____Age (s)_____
How is the relationship with their siblings? _____
How does the student interact with other children? _____
How does the student interact with teachers/other adults? _____
Other behaviors:_____

Health and Helping Professionals- Please fill those that apply.

Occupational Therapist:
Telephone:
Address:
City:
Zip:
Practice Name:

Physical Therapist:
Telephone:
Address:
City:
Zip:
Practice Name:

Speech Therapist
Telephone:
Address:
City:
Zip:
Practice Name:

Neurologist:
Telephone:
Address:
City:
Zip:
Practice Name:

Social Worker/Case Manager:
Telephone:
Address:
City:
Zip:
Group Home:

Child's caregiver/nurse/CAP worker's name: _____

Phone number: _____

Email: _____

Will this person bring child to class? _____

Class Policies

1. Our goal is always to provide our student with the best and most appropriate movement education program for their level of ability. The Foundation is the final decision-making authority with the regard to the curriculum and direction of all Foundation classes and programs.

2. All applications, medical history, and release forms must be completed and on file prior to the start of class.

3. Parents are not permitted inside the classroom. They may wait in an adjoining room.

4. Parents must call if their child is going to miss a class.

5. No food or drink is allowed in the Allegro classroom

6. When a student's behavior disrupts a class, the parents will be notified verbally and/or in writing. If disruptive behavior occurs on three occasions within two months, the student will be asked to leave the program. Should parents or guardians wish to appeal the decision, they may do so by asking for reconsideration by the evaluating committee.

7. Allegro cannot accept students who bite, pinch, or hit others. We must consider the safety of all participants.

8. Teaching movement education classes requires some physical contact and touching of students to demonstrate positions. Students with difficulties in this regard may not be candidates for our program and parents should consider their decision carefully to avoid dismissal from the program at a later date.

9. Each student must have bladder and bowel control or wear suitable undergarments. Students must be toileted before class. Please have your child in closed toed shoes not sandals or flip flops for class.

Release of Information
(Please check items you give permission for)

I_____give permission for

Yes/ No

☐ ☐ My child's school, teachers and support staff to share current IEP, IFSP or 504 Plan with Allegro Foundation for the purpose of assessment and evaluation.

☐ ☐ Allegro Foundation to share my child's IEP, IFSP, or 504 Plan; medical and personal records with Allegro's Medical Director and Assessment/Evaluation team for purposes of evaluation only.

☐ ☐ Allegro Foundation to test my child twice a year with the Allegro Foundation assessment and evaluation PF scale outlined in the parent packet of information.

Photo/Video Release

Yes/No

☐ ☐ I hereby give Allegro Foundation...a Champion for Children with Disabilities the absolute and irrevocable right and permission to use photographs and/or videos of Foundation classes or programs in which my child might appear in for the use in Advertising, public relations, or promotional purposes and/ or Demo tapes submitted with grant applications.

I/we further grant the Foundation permission:

- To copyright the same in their own name or any other they may choose.
- To use, re-use, publish and re-publish the same in whole or in any medium, for any purpose whatsoever, including (but not limited to) the uses listed above.
- To use my name in connection therewith if they so choose.

I hereby release and discharge Allegro Foundation from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.
This authorization and release shall also ensure to the benefit of the legal representatives, licensees and assigns of Allegro Foundation as well as the person/persons for whom they took the photographs or video.

I have reviewed and understand the policies of the Allegro Foundation as described above and agree to abide by them.

I have read and understand the above statements and release the Allegro Foundation…a Champion for Children with Disabilities, its Board, staff and volunteers, from responsibility for the medical care and treatment of my child, except in cases of emergency as described above.

_____ _____

Parent/Guardian Signature Date

Allegro Foundation…a Champion for Children with Disabilities (704) 412 –5229 www.allegrofoundation.net
***Please mail to: Allegro Foundation Or FAX to : (704) 371-8312
419 Ardmore Road Charlotte, NC 28209

Allegro Site:_____

Medical History and Release Form

(*MUST BE signed by Physician*)

Name of Patient: _____ Date of Last Physical Exam:_____Date of Birth: _____
Patient's Diagnosis: _____ Allergies:_____
_____

Vision Impaired____Hearing Impaired_____Sensitive to Sound____Yes____No **Developmental challenges**_____

Date of last EKG if heart condition is present: _____
Has patient had Varicella or vaccine?_____Yes/date_____No
Blood Pressure:____High ___Low_____Normal Height:_____Weight:_____
HEENT_____Neck_____Heart_____
Lungs_____Abdomen_____
Extremities UE_____LE_____
Neurogical_____
For students with Down syndrome, has a cervical spine x-ray evaluating atlanto-axial stability been done? If yes, include results:
_____
Explain patient's most recent surgery (with date):
_____

Please list any medications with dosages and side effects:

What, if any, side effects may result during periods of physical activity and social interaction?
_____

Please explain any concerns or recommendations with regard to participation in movement classes or performances:
_____

I approve of this patient's participation in Allegro Foundation's Movement/Education classes and public performances.

_____ _____ **Name of Physician:** _____
(Signature of Physician) **Date** **(please print)**

Address:_____**City:**_____**State:**_____**Zip:**_____
Telephone:_____**E-Mail:** _____