Authorizations Form

Participant Full Name _____

Release of Information

Initial to authorize release of records or information to the following (guardian initial) (co-guard initial)

(please check all that apply)

- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Speech Therapist
- ☐ Contracted Nursing Service
- ☐ Other: (identify exact agency) _____

Medical Administration (prescriptions)

Initial to authorize the administration of prescription medication by staff certified in Administration of Medication under the guidance of a Registered Nurse Trainer .

(guardian initial) (co-guard initial)

Authorization to Receive Therapy

Initial to authorize the following (please check all that apply) (guardian initial) (co-guard initial)

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Other _____

Signatures

Guardian / Date

_____

Relationship _____

Address _____

_____

Phone _____

Email _____

Co-Guardian (if applicable) / Date

_____

Relationship _____

Address _____

_____

Phone _____

Email _____