662-380-5170
662-380-5271
info@ebscioxford.com
www.ebscioxford.com
104 Skyline Drive | Oxford, MS 38655

Informed Consent

Child's Name: ____

CONSENT FOR THERAPEUTIC TREATMENT

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at EBS Children's Institute of Oxford. I understand that I may terminate these services at any time.

____ ____________________

Signature of Parent or Guardian Date

INVOLVEMENT IN CARE AND SERVICES

EBS encourages all clients and families to be an active member of the therapy session. Parent training and home generalization programs are critical for success and progress. I agree to be an active member of my child's treatment plan.

____ ____________________

Signature of Parent or Guardian Date

IF SHARED CUSTODY- both parties must sign this consent prior to treatment

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at EBS Children's Institute of Oxford. I understand that I may terminate these services at any time.

____ ____________________

Signature of Parent or Guardian Date

CONSENT FOR PARTICIPATION WITH THERAPEUTIC EQUIPMENT

Intervention programs at EBS Children's Institute of Oxford usually involve the use of specialized equipment such as various swings, bolsters, inflated therapy balls, climbing structures, tactile media (such as soap foam, Play-Doh and lotion), and a variety of other activities that involve fine, gross and oral motor coordination. Therapy activities often involve encouraging the child to try new in order to foster increased skills and abilities. While EBS staff make great efforts to ensure each child's safety, the

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nature of the therapeutic intervention includes the risk of falling, bumping into other people/equipment. I am aware of the inherent risk of this type of activity, and I give permission for my child to participate in therapy as described.

____ __________________

Signature of Parent or Guardian Date

REVIEW OF RECORDS/RELEASE OF INFORMATION

I consent to communication between EBS Children's Institute of Oxford and other therapists, teachers, and/or doctors that have previously worked and/or are currently working with my child. I understand that information and documentation may be shared with another member of my child's treatment team outside of EBS, as well as shared with professionals within EBS as part of the treatment process.

I understand that the information that is released between the treatment providers is confidential and is for the well -being of my child.

____ __________________

Signature of Parent or Guardian Date

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR THERAPEUTIC PURPOSES

Therapists often videotape or photograph children who receive therapy services at EBS to help monitor and document a child's areas of concern, as well as progress. Videotapes and photos are used and reviewed only by EBS staff. Parents are welcome to view their child's videotape at EBS.

I do____ do not____ give consent for my child to be videotaped and/or photographed as part of his/her therapy program for use by EBSCT staff only.

____ __________________

Signature of Parent or Guardian Date

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR EDUCATIONAL & PUBLIC AWARENESS PURPOSES

Staff at EBS are frequently asked to teach at courses, seminars or workshops. We often like to include videotape, slides or photos during our presentations. Additionally, we may occasionally use photographs to share on Social Media and for promotional purposes

I do___ do not___ give permission for my child to be videotaped/photographed for educational and public relations purposes. I understand that my child's name and any identifying information, will not be used in association with these images.

____ __________________

Signature of Parent or Guardian