

# In Harmony Pediatric Therapy

## **PERMISSION FOR PARENT TO LEAVE SITE DURING TREATMENT**

I, \_\_\_\_\_, acknowledge that I am the parent of \_\_\_\_\_.  
(Parent/Guardian Name) (Child's Name)

I understand that while my child is receiving therapy I may leave the premises. However, I understand that I will give to In Harmony Pediatric Therapy a working cell phone number where I can be reached during my absence. In addition, I agree that I will not travel more than ten miles from the satellite and will return prior to the end of the session. I give consent and permission to In Harmony Pediatric Therapy for any additional treatment or transportation that may be needed in the event my child is injured or needs medical attention. I understand that failure to comply with the requirements listed above will result in immediate revocation of this ability. Also, I understand that the ability to continue to leave the premises while my child is in therapy is at the discretion of In Harmony Pediatric Therapy and/or the therapist and may be revoked at any time.

I hereby release In Harmony Pediatric Therapy, and any agents as well as any assignees, from any and all claims for damages related to my leaving the premises during my child's therapy.

**Cell Phone Number:** \_\_\_\_\_

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**Secondary Emergency Contact Name & Phone Number**

Release is effective for estimated length of service for one year from \_\_\_\_\_.  
(date)

### **PARENT/LEGAL GUARDIAN**

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name

### **WITNESS**

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name