Dr. Colleen Ryan, PhD
Licensed Clinical Psychologist
Autism Spectrum Disorders Specialist

Childhood Autism Treatment Team
Childhood Autism Therapies
P.O. Box 192, 106 Main St
Palmyra WI 53156

262-370-7744 (Scheduling) **262-370-5527 (Billing)** **262-495-8689 (Fax)**

PEER-PLAY PARENTAL CONSENT AUTHORIZATION

Child's Name _____ Date of Birth_____

Street Address_____ City_____ State_____ Zip Code_____

I hereby authorize_____(my child) to participate as a peer in sessions designed to increase social and play skills with the following parties (list children).

_____

_____

_____

I understand that I and my child(ren) are free will participants, and that Childhood Autism Treatment Team, its officers, and employees, cannot be held responsible for an accidents or injuries that occur as a result of peer play, or occur during observation, and that I hereby release CHATT from any liability for what happens during play or observation.

Date Range Applicable _____(start) to _____(end)

_____
Signature of parent or legal guardian

_____
Date

I understand that I may revoke this consent at any time except to the extent that it has already been acted upon prior to my revocation. Revocation will be honored upon written notification.