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 PARENT & THERAPIST CONSENT AUTHORIZATION

Child's Name ________________________________ Date of Birth________________________________

Street Address____________________________________ City___________________ State_____ Zip Code________

I (parent) hereby authorize____(therapist) to

bring_______________________________________ to participate as a peer in sessions designed to increase social and

play skills with the following parties (list children).

____

____

I (therapist) hereby authorize_______________________________________(my child) to participate as a peer in sessions

designed to increase social and play skills with the following parties (list children).

____

____

We (both parties) understand that our 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

____
Signature therapist

____
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.