KIDSPLAY THERAPY CENTER, INC.

GCA

MALE ( ) FEMALE ( ) **Client Information** Today's Date:

Child's Name: _____ DOB: _____
First Middle Initial Last

Parent(s)/Guardian(s): _____

Address: _____ City: _____ Zip: _____

Phone: Home _____ Work _____

Cell _____ Email _____

IEP Received? YES NO

Therapy: Speech ( ) Occupational ( )

Therapist _____

☐Please check if you do not want to receive group emails with our current programs and activities.

Person responsible for payment: _____ _____

Teacher's Name: _____ Phone: Fax: _____