Summer Camp Registration 2025

Child's Name:_____DOB:_____ Age: _____

Parent/Legal Guardian Name:_____

Address:_____

Primary phone: _____Secondary phone: _____

Diagnosis :_____Email: _____

Payment Source: Private pay (No insurance billing for groups) _____Cash _____Check

FARM FRIENDS: July 9, 16, 23, 30

PRESCHOOL (AGES 3-5) 9:30-10:30 am._____

SCHOOL AGE (6-8) 11:00-12:00 pm. _____

SCHOOL AGE (9-10) 1:00-2:00 pm. _____

REGISTRATION MUST BE ACCOMPANIED BY REQUIRED FORMS AND PAYMENT TO HOLD A SPOT FOR YOUR CHILD:

Forms may be downloaded from the following website:

www.breezehilltherapy.com

1. EMERGENCY MEDICAL 2. RELEASE FORM 3. CLIENT HISTORY

Please return to:

Breeze Hill Therapy Services *3933 Withrow Rd *Hamilton, OH 45011 *Phone: 513-571-3697
*breezehilltherapy@gmail.com

*Fax: 833-636-2211

Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Breeze Hill Therapy, to:

1. Secure and retain medical treatment and transportation if needed.
2. Release any records upon the request to the authorized individual or agency involved in the medical emergency treatment.

Please describe any medical conditions that may require special precautions or treatment and any medications you are now taking:

_____

_____

List any allergies: _____

Client's Name: _____ Date of Birth: _____

Parents/ Guardian: _____

Address: _____

_____

_____

Primary phone: _____Name: _____

Other phone: _____ Name: _____

Email: _____ You may contact me by email: Y or N

Physician's Name: _____ Telephone #: _____

Person to contact in emergency (if parent or guardian cannot be reached first):

_____ Contact #: _____

Signature **Date** **Relationship**

RELEASE FORMS

Registration and General Release Form

I, _____ (Parent/Legal Guardian's Name), hereby apply for participation in Breeze Hill Therapy, LLC summer program. I acknowledge the risks and the potential for risks of the program's use of horses, other animals, and nature act activities. However, I feel that the possible benefits are greater than the risks assumed. I hereby forever release, discharge, and hold free and harmless, for myself, my heirs and assign, executors or administrators, all claims for damages against Breeze Hill Therapy, its therapists, instructors, aides, volunteers, and /or employees, and the Prushing Farm of any and all injuries and/or losses the client, client's family, or guests may sustain while participating in any programs.

_____ _____

Signature of Parent/Legal Guardian Date

Photo Release

I consent to and authorize the use of reproduction by Breeze Hill Therapy, LLC of any and all photographs and any other audiovisual materials take of the client, client's family, or guests while in treatment for use in promotional materials, educational activities, exhibitions, or for any other use of the benefit of Breeze Hill Therap., I also give consent for pictures (without names) to be posted on the Breeze Hill Therapy, Facebook, Pinterest, and Instagram pages.

_____

Signature of Parent/Legal Guardian Date

Damage Release

I, _____ (Parent/Legal Guardian's Name), hereby agree that I will be responsible for seeing that any children or guests brought by me on the premises of Breeze Hill Therapy, LLC are properly supervised at all times while on such premises. I agree to not bring any animals onto the property. I further agree that I will be liable for any damage to the property of Breeze Hill Therapy, LLC, the Prushing home, and/or for any loss of use of such property resulting from any such damage, caused by my negligence or that of any child or guest brought on such premises by me. I further agree to pay for any necessary repairs or to reimburse Breeze Hill Therapy, LLC and/or the Prushing family for the reasonable cost of repair, replacement, and/or loss of use of such property pending repair or replacement.

_____ Signature of Parent/Legal Guardian Date

SUMMER PROGRAM PARTICIPATION AGREEMENT AND CLIENT HISTORY

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

GENERAL INFORMATION

Client Name: _____ Date of Birth: _____
Age: _____ Height: _____ Weight: _____ Male or Female
School System: _____ Grade: _____

THERAPY HISTORY

What therapy services is the client currently receiving and where? (OT/PT/ST/counseling)

School: _____

Private: _____

HEALTH HISTORY

Medical diagnoses: _____

Medications: _____

Food restrictions: _____

Allergies: _____

Please give a brief description of your child in each of the following areas.

Vision: _____

Hearing: _____

Sensory issues: _____

Cardiovascular: _____

Seizures: _____

Pain/Joint/Muscular: _____

Behavioral: _____

Thinking/Cognition: _____

CLIENT SNAPSHOT

(Give us a picture of your child in the following areas)

Gifts/Talents: (Strengths, what your child brings to the group)

_____

_____

Physical function: (mobility, equipment, transfers, level of supervision needed)
_____

Language: (approximate # of words, signs, sentences)

_____

_____

Self care: (toileting status, feeding status)

_____

_____

We will not routinely change diapers/assist with toileting during groups unless it is a necessity. Please change your child right before the session starts.

If changing is required, do you give permission for a staff member to change your child/assist in the bathroom: Y or N

Social/Behavioral: (Describe your child's personality or any behavioral approaches used)

_____

_____

Goals: (What would you like your child to receive from this program?)

_____

_____

We look forward to working with your child.