

**PROGRAM REGISTRATION FORM**

**Brain Boosters Summer Group**

**Child's Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_

**Address (include city & zip code):**  
\_\_\_\_\_

**Phone Numbers: (H):** \_\_\_\_\_ **(C):** \_\_\_\_\_

**\*\*Medical Assistance # (if applicable):** \_\_\_\_\_

**Email Addresses:** \_\_\_\_\_

**Emergency Name/Phone Number:** \_\_\_\_\_

**Physical/Dietary Restrictions:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Current School (if any):** \_\_\_\_\_ **Current Grade:** \_\_\_\_\_

**Current Services Being Received (if any; Speech, OT, Psych., etc.)**  
\_\_\_\_\_

## Brain Boosters Summer Group

### SESSIONS AND HOURS

Session	Dates/Times	Cost
<b>Brain Boosters Mini-Session</b>	<b>Mondays, 3-4 PM June 11, June 18, June 25</b>	<b>\$250</b>
<b>Brain Boosters Full Program</b>	<b>Mondays, 3-4 PM July 16, 23, 30 August 6, 13</b>	<b>\$425</b>

**\*PAYMENT IN FULL IS REQUIRED TO HOLD YOUR CHILD'S SPOT**

***Please note the following procedures and policies:***

- 1) Application procedures may vary by program (i.e., when grouping by skills/age).
- 2) Applications will be reviewed and you will be notified of acceptance or the need for additional information and/or a screening.
- 3) Registration forms will be considered on a first come/first serve policy.
- 4) Group programs require consistent participation of all members. We ask that you adhere to this and make group attendance a priority for your child.
- 5) **LTC** reserves the right to cancel any program if there is insufficient enrollment.
- 6) **LTC** cannot store or administer any medications.
- 7) Make all checks payable to LEARNING AND THERAPY CORNER

**PICK UP AND DROP OFF**

The programs will be held at 1818 Pot Spring Rd, Suite 100, Lutherville. Suite 100 is located on ground level from the street, closest to the traffic light. Please be prepared to drop your child(ren) off on time and to pick up them up promptly at the end of the session. Therapists at the **LTC** have busy schedules and cannot be in the waiting area supervising children who have not been picked up on time. Please indicate who is authorized to pick your child up.

**The following ADULTS are authorized to pick up from the Learning and Therapy Corner.**

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**\*Please complete with contact persons to be reach in case of an emergency during the program.**

Name	Phone Number *	Alternate Phone Number*
1)		
2)		

**RELEASES-Please read carefully and initial/sign where required**

***EMERGENCY MEDICAL RELEASE*** (please initial one of the following)

\_\_\_\_ In the event of any injury or serious illness, I give permission for the Learning and Therapy Corner staff to obtain medical treatment for my child. I understand that if my child needs to be transported to an emergency facility that decision will be made by the emergency teams responding to the call.

OR

\_\_\_\_ In the event of an injury or serious illness, I do not give permission for the Learning and Therapy Corner staff to obtain medical treatment for my child. Instead, I instruct the Learning and Therapy Corner staff to:

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***LIABILITY RELEASE***

\_\_\_\_ By signing below I agree that the Learning and Therapy Corner assumes no liability for injury or damages arising from the result of participation in the activities unless due to willful fault or gross negligence on the part of the Learning and Therapy Corner.

**PARTICIPATION AUTHORIZATION**

(Must be completed to register)

I hereby approve my child, \_\_\_\_\_, to participate in the LTC Brain Boosters Summer Group. My signature confirms that the information provided is accurate, that the guidelines and procedures of the program will be adhered to and that it is my responsibility to keep the information provided current.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Please return these completed forms to the  
Learning and Therapy Corner, attention Karon Zablonksi or Amanda Farr  
1818 Pot Spring Road  
Suite 100  
Lutherville, MD 21093**

