

PROJECT CHILD CLINIC PROGRAM
MERCER COUNTY SPECIAL SERVICES SCHOOL DISTRICT
1068 Old Trenton Road, Trenton, NJ 08690 (609) 588-8500 FAX (609) 588-8503

Child's Name _____ Birth Date _____

 Last First Middle
Address _____ City _____ Zip _____

Home Phone Number _____ School District _____

Mother's Full Name _____ Cell Phone _____

 Employer _____ Work Phone _____

Father's Full Name _____ Cell Phone _____

 Employer _____ Work Phone _____

What concerns do you have about your child?

Referred by:

Has your child ever received assessment or services regarding your concerns? _____ No _____ Yes

If yes, please

list: _____

Please indicate the program you are interested in having your child attend:

- _____ Speech Clinic (30 minute weekly session, \$95 monthly tuition)
- _____ Perceptual/Motor Clinic (30 minute weekly session, \$95 monthly tuition)
- _____ Readiness Clinic (60 minute weekly session, \$95 monthly tuition)

Monthly tuition is due the first session of each month.

In the event of an emergency, it may become necessary for Project Child staff to take your child to the nearest hospital for treatment. The doctors in the emergency room can not examine or give treatment to a child without general information about the child and the written approval of the parent/guardian. Since many children attend Project Child with a babysitter or non-guardian family member, we ask that you sign below.

I hereby give Project Child the authority to have my child treated in the nearest hospital emergency room in the event I can not be reached. For safety purposes, I also understand that the adult accompanying my child must remain on-site for the duration of the Project Child Clinic Program session.

Date _____ Parent/Guardian Signature _____

OFFICE USE ONLY:

Staff Member _____ Date _____