



Sensory Solutions Summer Programs 2026

Child's Name _____ Birth Date _____ Age/Grade _____

Parents' Names _____

Address _____

Contact info. (Cell): _____

(E-mail): _____

Emergency Contact information - **Required**

Name / Relationship _____ Phone # _____

Please list allergies, food allergies, medical conditions, or special considerations.

Group Dates: June 23 - June 30, 2026 - Please Select

_____ **School Readiness: 4-5 year-olds, 9:30-11:30 (12 two-hour sessions at \$150 per hour)**
Tuesdays and Thursdays 9:30 -11:30

_____ **Lunch Bunch for Picky Eaters: 5-8 year-olds, 12:00-1:00 (12 one-hour sessions at \$225 per hour)**
Tuesdays and Thursdays 12:00 -1:00

_____ **Parent Talk: Free! Thursday, May 7 from 6:30-8:00**
_____ **Or Tuesday, May 12 from 6:30-8:00**

Groups may be reimbursed by your insurance company depending on your policy and the child's diagnosis. We will be using CPT code 97150 on superbills that you can submit to your insurance for reimbursement.

50% of the full payment is due at the time of registration.

The remainder of the payment in full, a screening (if applicable), and all intake paperwork are due June 1, 2026, or your child's spot may be forfeited.

Cancellations made between April 10 and May 8 will be refunded at 75%.

Cancellations between May 9 and May 31 will be refunded 50%.

Cancellations between June 1 and June 23 are non-refundable.

*Preparation for these groups requires months of planning and much of the planning is tailored to the needs of the children enrolled in the program. Changes made to the roster after June 1st are difficult and costly to our team members.

_____ (Initial) **In the event of the need for emergency medical attention, I give consent for 911 personnel to provide essential care for my child.**

_____ (Initial) By registering my child, I give permission for my child to receive occupational therapy treatment from Sensory Solutions, LLC. I am aware that the group sessions may be held offsite.

_____ (Initial) I give permission for photographs to be taken of my child for therapeutic purposes and future marketing if the child is not identifiable.

_____ (Initial) Snacks will be provided by Sensory Solutions, however, lunch must be provided by families for the Lunch Bunch Group.

*Both parent signatures are required.

Parent's Signature _____ Date: _____

Parent's Signature _____ Date: _____