The ABA Clinic at Beyond the Spectrum
7333 International Place
Lakewood Ranch, Florida 34240

SUBJECT: ABA services for your child

Dear Prospective Client,

Thank you for your interest in our ABA clinic. The following pages briefly outlines who we are, the process of getting started, and the client registration forms necessary. The registrations forms within provide us with information to assess how we can best service your child and family. With all these documents completed, we may begin the process on our end toward beginning treatment.

Once you have completed the documents, please drop off or mail them to the address above, together with a copy of your insurance card(s), front and back and the prescription for ABA Services (if these have not already been provided).

Should you have any questions, comments or concerns, please do not hesitate to contact us! Thank you again for your interest in our company and we look forward to getting to know your family and child.

Sincerely,

Lora Carpenter, Executive Director
Amy Labrie, MS, BCBA

 Phone: (941) 907-3443 Fax: (941) 527-0526 Email: abaclinic@beyondthespectrum.org

REQUIREMENTS FOR ABA SERVICES

PARENT RESPONSIBILITY

1. Completed Registration Packet

_____ Initialed pages 4-8
_____ Intake and Assessment form
_____ Statement of Authority to Consent
_____ Treatment Consent Form for ABA Services
_____ Consent to Participate in Assessment and Records Release
_____ Authorization to Discuss Information
_____ Client Notification of Privacy of Rights (HIPPA Notice of Privacy)
_____ Confidentiality Act/Abuse Reporting Protocol
_____ Authorization to Bill Insurance
_____ Authorization to Release Medical Information to Insurance Company
_____ Financial Responsibility
_____ Cancellation/No Show Policy
_____ Grievance/Discharge Policy
_____ Permission to Videotape and Photograph
_____ IEP
_____ Psychological Evaluation (if applicable)
_____ Prescription for ABA services

CLINIC RESPONSIBILITY

1. Clinic to obtain pre-approval from insurance company (if applicable) is required prior to any evaluation, therapy, or other service.

2. Parents Meeting to tour clinic and review intake process and procedures/policies

3. Intake conducted by BCaBA/BCBA (may take 4+ observations/meetings to conduct)
   *Parent Meeting/Interview as part of the FBA
   *Assessment that is appropriate for your child (VB-MAPP, ABLLS, AFLS, etc.)

4. Behavior plan submitted to insurance company for approval

5. Parent meeting to review reports and discuss goals, treatment plan and schedule

6. The majority (at least 75%) of direct therapy will be conducted by a Registered Behavior Technician (RBT) who has been trained by the Analyst. The RBT will continue to receive ongoing supervision by the Analyst. The Analyst will provide up to 25% of direct therapy.

7. Monthly staff meetings to review progress

8. Biannual assessments to evaluate progress and update behavior plan.

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MISSION

Our mission at Beyond the Spectrum is to serve the children and families in our community affected by autism and related disorders. By providing individualized therapeutic and educational services and utilizing the expertise of our professionally trained staff, our goal is for each child to achieve their highest potential in a safe, caring and family-friendly environment.

PHILOSOPHY

At Beyond the Spectrum, we believe that every child deserves to be loved and accepted for who they are. We are here to support both the children and families of our community who are affected by Autism and other related disorders. Let us show how the culture at Beyond the Spectrum can make a meaningful impact on the life of your child.

The Clinic at Beyond the Spectrum supports evidenced-based treatment methods based upon the procedures and principles of Applied Behavior Analysis (ABA) inclusive of Natural Environment Teaching (NET), Discrete Trial Instruction (DTI), Verbal Behavior strategies and Direct Instruction. We recognize the need to work the families of our clients as well as collaborate with his/her other therapists.

Each client has an *individualized* program designed to address his/her needs. Once we determine the client has met treatment eligibility requirements and assure our clinic is an appropriate placement for him/her, we begin the treatment process. To design a treatment package that best meets the client needs, our initial assessment includes but is not limited to Functional Behavior Assessments, Preference Assessments, VB-MAPP and ABLLS-R. Each skill area is designed to foster each child's independence and functioning. Goals are established with the collaboration of parents/caregivers and other professionals as part of the multidisciplinary team.

CONTACT INFORMATION

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Lora.carpenter@beyondthespectrum.org
941-907-3443

Amy Labrie, MS, BCBA
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AN OVERVIEW OF THE ABA APPROACH TO THERAPY
ABA THERAPY

Applied behavior analysis (ABA) is the scientific approach to understanding behavior and the functional relationship between variables in the individual's environment and the targeted behavior. Data is collected and analyzed to assess this relationship between the environment and the behavior. Data is also collected to monitor progress throughout the course of therapy. The goal of ABA therapy is to target behaviors which are socially significant to the development and quality of life of each client. Therapy can include, but is not limited to targeting speech, language, school/academic readiness, social skills, play and behavior management. Treatment is individualized to the client's strengths and work to decrease skill deficits. Research has indicated that intensive ABA therapy is very effective at reducing and replacing behaviors that interfere with learning and development. ABA utilizes behavioral contingencies to help client's learn functional skills to replace undesirable behaviors.

More information about ABA, including podcasts and resources to help families understand the field and treatment, can be found at www.behaviorbabe.com or https://www.autismspeaks.org/applied-behavior-analysis-aba-0

INDIVIDUALIZED PROGRAMING

Because we recognize that each client is unique and special, we take seriously the need to individualize his/her behavior intervention plan. Our BCBA/BCaBAs continuously assess the client's needs and utilize the most recent literature/research to support this individualized plan. Our staff (BCBAs, BCaBAs and RBTs) receiving ongoing training and education to ensure we are educated in a wide range of ABA methods as to meet the needs of all our clients.

ASSESSMENTS WE MAY CONDUCT

FBA

A Functional Behavior Assessment (FBA) is an assessment that is conducted to better understand the concern of the client/caregiver. An analyst will conduct an FBA to:

a. identify behaviors of concern in observable and measurable terms;
b. identify events/situations which predict the demonstration of target behaviors and;
c. identify what function those behaviors serve and determine alternative behaviors that can be taught.

To achieve this, the analyst will review records and reports, interview the client and/or caregiver, directly observe the client (in a variety of settings if appropriate) and collect and analyze data collected, develop hypotheses that describe the behavior, the situations in which they occur and the outcome, then recommend and implement interventions based upon research that supports the hypotheses. When the FBA does not produce a reliable hypothesis, additional analysis may be necessary.

VB-MAPP

Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) was created by Dr. Mark Sundberg as a means of assessing children with disabilities and other related diagnoses. The VB-MAPP is based upon B.F. Skinner's analysis of verbal behavior, ABA research and developmental milestones. Children are assessed across five domains and the results provide baseline performance and a tool for curriculum planning and a direction for intervention. This assessment is developmentally balance across verbal operants and other skills while also allowing for an assessment of barriers to learning. Other features of this assessment allow for an evaluation of the level of inclusion or group instruction a child may need (based upon the transition assessment).

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ABLLS-R

Dr. James Partington created The Assessment of Basic Language and Learning Skills – Revised, which is an assessment tool, curriculum guide and skills tracking system use to help guide language instruction and other critical learner skills for children with autism or other developmental disabilities. This criterion referenced assessment contains an outline of many skills necessary to learn and communicate successfully. This assessment also provides baseline performance and serves as a tool for curriculum and intervention planning.

AFLS

The Assessment of Functional Living Skills (AFLS) is an assessment, created by Dr. James Partington, which assesses individuals using a skill tracking system and curriculum guide for developing the essential skills for independent and functional living. This tool creates a baseline performance and offers a progressive track for the development of these essential skills. Skills targeted consist of those necessary for work, community and family settings and participation.

Other assessments may be used based upon the individual needs of the client.

BEHAVIOR INTERVENTION PLANS

Behavior Intervention Plan (BIP) is a plan of intervention created based upon the behavior analyst's assessments and the existing literature. A behavior plan will address the client's present baseline level of skill and outline specifically short- and long-term goals. These goals are reached via addressing behaviors to increase and behaviors to decrease. With each behavior we look to decrease, we will look to teach/increase at least one other skill that will fill the same function for the individual. Behavior plans are emphasized using reinforcement rather than the use of punishment-based procedures.

Each behavior intervention plan written is specifically tailored to the client's goals, needs and strengths and weaknesses.

STAFFING

Each client will have a Board Certified Behavior Analyst (BCBA) or Board Certified assistant Behavior Analyst (BCaBA) as the lead supervisor for his/her treatment. A Registered Behavior Technician (RBT) will provide direct (1:1) therapy in the clinic or school setting. All therapists are certified through the Behavior Analyst Certification Board.

PARENT GUIDELINES

We recognize the importance of working with you toward the achievement of the goals for your child. We want to ensure that our communication is open so that we may continue to work toward these goals. Please communication any questions, comments or concern you have at any time.

Sickness: please notify the therapist, in as much advance as possible, at least the night before the scheduled session if you know that your child will not be in the next day due to an illness. Sickness includes, but is not limited to

- Temperature at or above 100
- Communicable Disease
- Hand/Foot/Mouth
- Vomiting
- Measles, mumps, chicken pox
- Diarrhea
- Pin worm
- Strep throat
- Lice
- Rash
- Pink eye

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Clients must be fever/symptom free for at least 24 hours prior to returning to the clinic. If your child has a rash, please do not return to the clinic without a doctor's note clearing him/her to return.

Except in cases of emergency, 12-hour notice is required for all cancelled sessions. Because consistency is critical to the success of treatment, if sessions are cancelled in excess (3 times within 1 period of time), services will be terminated. For more information, please see the Cancellation/No Show Policy in this packet.

We request that families give us at least two weeks' notice on significant changes in their plans for ABA therapy to help facilitate consistency in therapy. This notice will allow for fading and/or transitioning therapy.

Parents and therapists should be respectful and courteous to each other. Open communication between parents and therapists is essential to the establishment of a successful program for the child. If there are any problems for concerns, please contact the office (additional information available in the grievance section of this handbook).

Because it is always important that our attention be with the client, we request that all communication go through the office or staff email. We can always schedule a meeting to discuss questions/comments/concerns that are not appropriate for phone or email. In the event of an emergency, our office will notify us immediately. Communication with employees via personal cell phones or any social media outlet is not permitted.

We understand that there may be times when you would like to show your child's therapist your appreciation; however, the board that oversees our certification prohibits our RBTs, BCaBAs, and BCBAs from accepting gifts.

Please understand that all information shared is HIPPA protected, it is essential that every ABA clinic employee respects and maintains each client's right to confidentiality regarding his/her treatment and all personal information. All HIPPA laws apply. Please do not ask about other clients' program or treatment, as this information will not be discussed and could possibly lead to the dismissal of your student from the program.

SERVICE AGREEMENT AND CONSENT FORM

This packet contains information about our services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI used for the purpose of treatment, payment, and health care operation). HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires we obtain your signature acknowledging we have provided you with this information. Although these documents are long and sometimes complex, it is very important you read them carefully and you ask questions regarding the procedures. When signing this document, it will also represent an agreement between our clients/caregivers and the ABA Clinic at Beyond the Spectrum. You may revoke this agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed by your health insurer to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations. If you have any questions or concerns, please feel free to bring them to our attention.

SERVICES AND DISCHARGE

The ABA Clinic at Beyond the Spectrum offers an individualized ABA program. To determine the program needed for each client, we initially complete an assessment to determine whether the client would benefit from our services. When it is determined that our services are needed, a BCBA will continue to work with you and develop a behavior plan based on the findings of the assessment and existing research.

The behavior plan includes general and specific goals with time frames for mastery; goals are reassessed every 6 months. The behavior plan is then implemented by the BCBA who supervises Registered Behavior Technicians on proper implantation of the treatment plan, data collection and ensures for fidelity. The behavior plan is ajusted as needed based upon client progress toward goals; decreasing criteria if too challenging or expanding goals which are found to be too

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easy. If, after adjusting the treatment plan and following the updated plan we may determine our services are not the proper treatment for the client. If such a determination is made, we will follow our discharge and referral protocol.

Once the client has attained the level of development similar to a typical developing child, the client will be put on a maintenance program until the BCBA determines services will no longer benefit the client. A sudden stop in services can be detrimental to skills acquired, as such, discharge from services is done over a long period of time to achieve a smooth transition for the student and family.

TO PROTECT THE CLIENT OR OTHERS FROM HARM

If we have reason to suspect that a client or other minor is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions, which could include notifying the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

CONFIDENTIALITY, RECORDS, RELEASE OF INFORMATION AND PROFESSIONAL CONSULTATION

Services are best provided in an atmosphere of trust; because of this, all services are confidential except to the extent that we are provided with written authorization to release specified information to specific individuals/agencies.

Behavior Analysts routinely consult about cases with other professionals. In doing so, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal. We will inform clients of these consultations. If you want us to talk with or release specific information to other professionals with whom you are working, you will need to sign an authorization specifying what information can be released and with whom it can be shared.

BILLING AND PAYMENT
CHANGING FEE STRUCTURE

The fee structure for all services rendered through the ABA Clinic at Beyond the Spectrum is subject to change. Clients will be made aware of such modifications 30 calendar days prior to the effective day of any change.

PAYMENTS

We accept cash, check, or credit card for payments. Invoices are billed monthly. Payment is expected by the end of the billed month. If payment cannot be made or you have any billing/payment questions, please contact Peggy Caruso at peggy.caruso@beyondthespectrum.org, or at 941-447-8400.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in one set of professional records. The Clinical Record includes information about reasons for seeking our professional services; the impact of any current or ongoing problerns or concerns; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Personal notes are taken during supervision sessions by the Registered Behavior Technician and/or Behavior Analyst. While the contents of personal notes vary from client to client, most are anecdotal notes related to progress and future goals, reference to conversations, and hypotheses ofthe professional. These Personal Notes are kept separate from the Clinical Record are not available to you and cannot be sent to anyone else, including the insurance company. Your signature below waives all rights, now and in the future, to accessing these records in any form under any circumstances. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT'S RIGHTS

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HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

CONTACTING US

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends.). If you are difficult to reach, please leave your availability within the message. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms described above.

Child's Name	Date
Parent/Guardian Printed Name	Parent/Guardian Signature

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CONSENT TO PARTICIPATE IN ASSESSMENT AND RECORDS RELEASE

Client: _____ D.O.B.: _____

Address: _____

_____

Phone: _____ Alternative Phone: _____

Parent/Legal Guardian Name: _____

I consent for the above-named individual to participate in assessment through the ABA Clinic at Beyond the Spectrum. I consent to have the assessment with the above-named individual conducted at the following locations

- ☐ Home _____
- ☐ School _____
- ☐ Other _____

Parent/Legal Guardian: _____ Date: _____

I understand and consent to have the individuals responsible for care in the above-named locations involved in the assessment of the above-named individual. To coordinate the assessment with these individuals, I authorize the release of the following confidential records to the individuals responsible for care in the above-named locations:

- ☐ Insurance Information
- ☐ IFSP or IEP
- ☐ Medical records
- ☐ Semi Annual and Annual Reports
- ☐ Behavior program or Treatment Plans
- ☐ Other _____
- ☐ Psychosocial History
- ☐ Progress Notes

I understand records may contain psychiatric and or drug and alcohol information. I understand that these records may also contain references to blood borne pathogens (e.g. HIV, AIDS).

I understand that my records are protected by data practice laws and cannot be release without mt consent unless otherwise allowed by law. Only the information and records indicated above will be released or obtained and consent does not authorize the recipient of the information/records to re-disclose the information/records to any other person or facility unless authorized by law.

I understand that the information will only be used for the therapy of the above-named client, and I may withdraw or modify this consent at any time but the modification/revocation will not affect any previously released information.

Information may be shared in person or by mail. I give permission to share information using the following methods:

- ☐ Phone
- ☐ All
- ☐ Other _____
- ☐ Email
- ☐ Verbal
- ☐ Fax
- ☐ Written

I understand that the ABA Clinic at Beyond the Spectrum will maintain individual's records in a safe and locked location and maintain protected electronic records of individual data.

THIS CONSENT AUTOMATICALLY EXPIRES 1 YEAR AFTER TERMINATION OF SERVICES.

Parent/Guardian: _____ Date _____

_____ Parent Initials

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EMERGENCY INFORMATION AND CONTACTS

Client's Name: _____

DOB: _____	Height: _____	Weight: _____
Diagnosis: _____		
Allergies: _____		
Pre-Existing Conditions: _____		
Other Medical Concerns: _____		
Medications (name, dose and times administered) _____		
Significant Behaviors:		
Self-Preservation Skills: _____		

Primary Emergency Contacts

Parent's name: _____		Home address: _____	
Home phone: _____			
Daytime phone: _____			
Cell phone: _____			
Email: _____			
Parent's name: _____		Home address: _____	
Home phone: _____			
Daytime phone: _____			
Cell phone: _____			
Email: _____			
Doctor's name:		Office phone:	

Insurance Information

Provider: _____	Card/Policy #: _____
Primary Subscriber: _____	Medicaid #: _____

Additional Emergency Contacts

Name: _____	Phone: _____
Address: _____	Relation: _____
Name: _____	Phone: _____
Address: _____	Relation: _____

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I give permission for the following people to pick up my child:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

SEIZURE PLAN

Client Name: _____ DOB: _____

Address: _____ Phone: _____

Emergency Contacts

Name:	Phone:
Relationship:	
Name:	Phone:
Relationship:	

Seizure Information

Seizure Type	What Happens	Duration	Frequency

Triggers: _____

_____

Daily Seizure Medicine

Medicine Name	Dose	How/When Administered

Other seizure treatments

Device type: _____ Model: _____ Date implanted: _____

Serial #: _____

Dietary Therapy: _____

Special Instructions: _____ Other Therapy: _____

Seizure First Aid	Call 911 if. . .
☐ Keep calm, provide reassurance, remove bystanders	☐ Generalized seizure longer than 5 minutes
☐ Keep airway clear, turn on side if possible, nothing in mouth	☐ Two or more seizures without recovering between seizures
☐ Keep safe, remove objects, do not restrain	☐ As needed treatments don't work
☐ Observe and record time and duration	☐ Injury occurs or is suspected, or seizure occurs in water
☐ Other care as needed: _____	☐ Breathing, heart rate or behavior doesn't return to normal
	☐ Unexplained fever or pain, hours or few days after a seizure
	☐ Other care needed: _____

When Seizures Require Additional Help

Type of Emergency (long, clusters or repeated events)	Description	What to Do

_____ Parent Initials

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"As Needed" Treatments (VNS magnet, medicines, etc.)

Name	Amount to Administer	When to Administer	How to Administer

Health Care Contact

Epilepsy Doctor:		Phone:	
Nurse/Other Health Care Provider:		Phone:	
Preferred Hospital:		Phone:	
Primary Care:		Phone:	
Pharmacy:		Phone:	

Special Instructions

Parent/Guardian Signature	Date	BTS Staff Signature	Date

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MEDICATION ADMINISTRATION IN SCHOOL OR CHILD CARE

Name: _____ DOB: _____

The parent/guardian of _____ ask that school/child care staff give the following medication _____ (name and dose) at _____ (time(s)) to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. The parent agrees to pick up expired medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medication, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.
Over the counter medication must be labeled with child's name. dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medicine with the nurse or school staff delegated to administer medication.

Signed this ____ day of _____, 20__

_____ _____
Printed name of parent/guardian Signature of parent/guardian

_____ _____
Work Phone Home/Cell Phone

****

HEALTH CARE PROVIDER AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL OR CHILD CARE

Child's Name: _____ DOB: _____
Medication: _____ Dosage: _____
Route: _____ Administered at the following time(s): _____
Special instructions: _____
Purpose of medication: _____
Side effects that need to be reported: _____
Starting date: _____ Ending Date: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority License Number

_____ _____
Phone Number Date

Please ask the pharmacist for a separate medicine bottle to keep at school/childcare.

_____ Parent Initials

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Thank you!

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GRIEVANCE/ DISCHARGE PROCEDURE

Grievance: If you are not satisfied with the services you receive by the staff assigned to you, please first call the behavior analyst assigned to your case. If you have a grievance with the BCBA/BCaBA/RBT or are not satisfied with the manner in which your concerns are being addressed, you may file a grievance directly with the Behavior Analyst Certification Board (BACB). If the issue is not resolved, the services may be terminated.

Discharge: The behavior analyst reserves the right to discontinue or discharge treatment in the instances of:

1. Any parent or caregiver that refuses to follow a treatment plan and has been reminded of the contract they signed stating that it is indeed the family's responsibility to follow a plan
2. Any child whom ages out of coverage (22 yrs. and no longer in school)
3. Any individual that is not improving despite exhausting all known interventions, procedures, and or research-based strategies.
4. Goals have been met and maintained; therapy faded
5. The clinic has had staff leave and are no longer able to staff your child's therapy
6. Violation outlined in the Cancellation/No Show Policy
7. Failure to pay for services

If an individual is discharged, it is of best practice that the analyst provides a list of other providers and professionals in their area with the background and expertise to provide support services to the individual and their family.

Disclaimer: The analyst will in no way turn down a family for coverage, no will they discharge or discontinue treatment based on race, creed, sexual orientation, wealth, etc.

I understand the Grievance and Discharge Policies. An analyst has taken the time to explain these to me.

Parent/Guardian: _____ Date: _____

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AUTHORIZED PICK-UP AND CLIENT RELEASE FOR _____ (CHILD'S NAME)

Beyond the Spectrum uses the following criteria to assure each child is picked up or removed from the preschool by authorized persons only:

1) No child will be released to any person whose name does not appear on this Authorization Pick-Up List or has been approved and added by using the Authorization Addition Form.

2) Before any person can remove a child, proper ID, such as a current driver's license, must be shown

3) If there is ever any question as to the identification of any person attempting to remove a child from the premises, the legal guardian will be notified immediately

4) The legal parent/guardian must give advanced written authorization before any person not appearing on our Authorized Pick-Up List will be allowed to remove a child from the premises

5) In the event of an emergency, the legal parent/guardian may give above stated permission verbally, but only if given directly to the Administrator or authorized office personnel. This new pick up person will not be added to the permanent list unless you specify.

6) All authorized pick-up persons MUST complete the Authorization Affidavit, in order to enter the facility

For your child's protection, THEY WILL NOT be released to an unauthorized person. Approved picture identification (driver's license) will be required. A list of these persons will be placed in each classroom.

List below those who have permission to pick up your child:

Name:	_____	Relationship:	_____	Phone:	_____
Name:	_____	Relationship:	_____	Phone:	_____
Name:	_____	Relationship:	_____	Phone:	_____
Name:	_____	Relationship:	_____	Phone:	_____
Name:	_____	Relationship:	_____	Phone:	_____
Name:	_____	Relationship:	_____	Phone:	_____
Name:	_____	Relationship:	_____	Phone:	_____

Beyond the Spectrum (BTS) defines a legal parents or legal guardian to be person(s) who enrolled the child and whose signature is found on the enrollment form. In the case where a divorce or legal separation has occurred or is in the process, legal court documentation must be presented as proof that he/she has been awarded temporary or permanent custody of the child in question. We will not hesitate to call 911 immediately if any disruptions or disputes develop on school property.

The safety or the minor child in our custody will always take top priority in any situation. This also applied to those allowed to pick up the child from BTS. ONLY official court documents, whose authenticity has been verified, will supersede any other documents received or placed on file.

I hereby authorize all above listed names as active and approved people to pick up my child from the Beyond the Spectrum facility.

_____ Parent Initials

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Parent/Guardian Printed Name

Parent/Guardian Signature

Date: _____

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