DEI'S CARE
BIBLICAL CARE FOR CHILDREN WITH AUTISM

Consent for Authorized Participants

I _____ authorize the following persons to participate in

Client Name: _____ DOB:_____

services and treatment for the purpose of generalizing skills, monitoring, and/or transporting. I understand that my child may not be treated unless myself and/or the person's name listed below is present. I understand that Dei's Care Consulting is not responsible for my child's safety and I or the person (s) listed below will be solely responsible for the safety of my child on or off site. *** I also understand that my child will not be released into the care of any persons that are not listed below.

Person 1)_____ Relationship_____ Phone:_____

Person 2)_____ Relationship_____ Phone:_____

Person 3)_____ Relationship_____ Phone:_____

Person 4)_____ Relationship_____ Phone:_____

Person 1)_____ Relationship_____ Phone:_____

Parent or Guardian (Please Print)_____

Signature:_____ Date_____

Witness (Please Print) _____

Witness Signature:_____ Date_____

****The staff of Dei's Care Consulting follows the "Good Samaritan Rule" in which the adult closest to the client will intervene if he or she is in severe danger of hurting self or others.*

We may update this from time to time, please check the date given below for the latest update. Last updated 5/1/20