

360 LIFE CHANGES OF SOUTH FLORIDA

APPLIED ABA SERVICES PROGRAM PARTICIPATION CONSENT FORM



CHILD INFORMATION

Child's Full Name:	
Child's Date of Birth:	
Child's Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Child's School Name:	Grade / Level in School: (if applicable)
Date to Begin Training:	
Known Behavioral Triggers / Sensory Sensitivities: (e.g., loud sounds, certain textures, transitions, crowds – anything staff should be aware of) _____ _____	
Does your child have any known allergies? (food, environmental, medication, materials, latex, etc.) <input type="checkbox"/> No known allergies <input type="checkbox"/> Yes – please describe: _____ _____	
Current Medications (if applicable): _____	
Does your child have a history of seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child require an EpiPen, inhaler, or other emergency medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain: _____ _____	

Any additional medical, dietary, or safety information staff should be aware of:

Has your child previously received any of the following services? (Check all that apply)
<input type="checkbox"/> Applied ABA Services / ABA Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Early Intervention Services <input type="checkbox"/> Special Education / IEP / 504 Plan <input type="checkbox"/> Private Tutoring <input type="checkbox"/> None
If yes, briefly describe:

PARENT / GUARDIAN INFORMATION

Parent / Guardian #1 Name:	Relationship to Child:
Phone:	Email:
Parent / Guardian #2 Name: (if applicable)	Relationship to Child:
Phone:	Email:
Preferred Method of Communication: <input type="checkbox"/> Phone Call <input type="checkbox"/> Text Message <input type="checkbox"/> Email	Primary Language Spoken at Home: _____

EMERGENCY CONTACT (other than parent/guardian listed above)

Emergency Contact Name:	Relationship to Child:
Phone (Primary):	
Phone (Secondary):	

AUTHORIZED PICK-UP / RELEASE INFORMATION

The following individuals are authorized to pick up my child from 360 Life Changes of South Florida programs or activities:

Name: _____

Relationship: _____ Phone Number: _____

Name: _____

Relationship: _____ Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

No individual other than the parent(s)/guardian(s) listed on this application may pick up my child without prior written, text, or verbal authorization from the parent/guardian.

PROGRAM SELECTION

Which program are you signing up for? (Select one)

- Applied ABA Services / Early Learning Tutoring — Ages 2–6
- Applied ABA Services / Early Learning Tutoring — Ages 7–11
- Applied ABA Services / Early Learning Tutoring — Ages 12–17
- Special Activity — 1 Hour Event Session
- 1:1 Individual Session (check here if you are requesting a one-on-one session)

PROGRAM SELECTION

Which program are you signing up

Enrollment Type: (Select one)

- Term Enrollment (Opening Enrollment — commit to the full program term)
- Individual Sessions (Book sessions as needed)

SESSION DETAILS

Session Date(s) / Time Slot(s): _____

Weekly Attendance Preferred: Yes No

Designated Service Location: _____

Home Session Address (if applicable): _____

INTAKE & CONCERNS

Parent/Guardian Concerns: _____

Teacher / School Concerns: _____

Child's Current Diagnosis / Diagnoses: _____

DIAGNOSTIC INFORMATION

Does your child currently have an active diagnostic evaluation on file?

Yes No

Does your child need a diagnostic evaluation? Yes No

FOR OFFICE USE ONLY

360 Assessment Completed: Yes No

Assessment Date:
Completed By:
Program Assigned:
Notes:

PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING. IT AFFECTS YOUR LEGAL RIGHTS.

IMPORTANT NOTICE:

360 Life Changes of South Florida provides Applied ABA Services. We are not a licensed ABA therapy center. Our services are provided by a Registered Behavior Technician (RBT) with years of hands-on training and experience. These sessions are educational and supportive in nature, designed to supplement, not replace, professional medical or therapeutic treatment.

SECTION I: IDENTIFICATION OF RISKS AND ASSUMPTION OF LIABILITY

In consideration of the opportunity for myself or my child to participate in the Applied ABA Services (the "Program") offered by 360 Life Changes of South Florida, I voluntarily release, waive, discharge, hold harmless, and covenant not to sue the organization and its representatives from any and all liability arising from participation in the Program.

SECTION II: ACKNOWLEDGMENT AND ASSUMPTION OF RISK

I acknowledge that participation in Applied ABA Services sessions involves inherent risks including physical injury, emotional or behavioral escalations, exposure to communicable diseases, and other unforeseen incidents.

SECTION III: MEDICAL FITNESS AND EMERGENCY CONSENT

I affirm that I or my child is fit to participate in the Program and authorize emergency medical care if necessary.

SECTION IV: INSURANCE ACKNOWLEDGMENT

I understand that 360 Life Changes of South Florida does not provide medical or liability insurance coverage for participants.

SECTION V: PHOTO, VIDEO, AND MEDIA RELEASE

To help us communicate progress and celebrate participation, photographs and videos may occasionally be taken during sessions and activities.

Please indicate your preferences below:

Permission for photos/videos to be shared privately with parents or guardians for progress updates:

Yes No

Permission for photos/videos to be used for marketing, promotional materials, social media, website content, brochures, flyers, or educational purposes:

Yes No

Permission to use my child's first name in conjunction with approved media:

Yes No

I understand that I may revoke media permissions in writing at any time; however, materials already published or distributed prior to revocation may not be able to be removed.

SECTION VI: PRIVACY AND DATA COLLECTION CONSENT

I consent to the collection of personal information necessary for registration, assessment, and program coordination.

SECTION VII: SCOPE OF SERVICES ACKNOWLEDGMENT

I understand that Applied ABA Services are educational and supportive in nature and are not licensed therapy or medical treatment.

SECTION VIII: GENERAL RELEASE AND GOVERNING LAW

This Agreement shall be governed in accordance with the laws of the State of Florida.

SECTION IX: PROGRAM PARTICIPATION, ATTENDANCE, AND EXTENDED PROGRAM OPTIONS

To support consistency and allow us to properly identify your child's current level, learning needs, and primary goals, families are strongly encouraged to book at least **1 month of appointments in advance**. Consistent attendance during that time helps us better establish where your child is at and what main goals should be worked on.

During this 1-month period, **1 absence is allowed**. If appointments are attended randomly or without consistency, future sessions will be created based on the assessment and information available at the time you decide to book your next appointment.

4-Month Program

Our **4-month program** is structured as indicated and is designed to provide continued educational and behavioral support through a more consistent format. During this program, we work through the **360 Life Changes textbook** for **30 minutes**, followed by **30 minutes** of preferred choice activities and/or implied ABA-based training support.

This structure is intended to help support learning, participation, routine-building, and individualized goal-focused practice over time.

Extended Program Activity

Our **Extended Program Activity** is available for children who would like to attend a **1-hour educational fun activity program**. This program is open to the following age groups:

- Ages **2-6**- Ages **7-10** - Ages **11-14** - Ages **15-17**

This program includes:

- Age-appropriate educational activity worksheets
- A creative arts and crafts activity

The Extended Program Activity is purchased through the **product page** and **does not require a 360 assessment before purchase**. However, for child safety and program planning purposes, the application is still required to be **completed** before participation.

**SECTION X: CANCELLATION, ATTENDANCE, AND RESCHEDULING
ACKNOWLEDGMENT**

I understand and acknowledge the attendance expectations of the program.

- Consistent attendance is strongly encouraged to support learning and progress.
- Parents/guardians are responsible for notifying staff as soon as possible regarding cancellations or scheduling changes.
- Missed sessions, late arrivals, and rescheduling requests may affect program planning and availability.
- Refunds, credits, and make-up sessions are subject to current program policies.

Parent/Guardian Initials: _____

SECTION XI: FINAL ACKNOWLEDGMENT AND SIGNATURE

BY SIGNING BELOW, I CERTIFY THAT:

- I have read and understand this document.
- I am voluntarily signing this agreement.
- I understand this is a legally binding document.
- If signing on behalf of a minor child, I certify that I am the child's parent or legal guardian and have authority to enter into this agreement.

Participant/Parent or Guardian Name (Printed): _____

Signature: _____ Date: _____

Participant's Name (if different): _____

Relation to Participant: _____

Staff Witness Name (Printed): _____

Staff Witness Signature: _____ Date: _____

