PERMISSION FOR IN-SCHOOL SERVICES

STUDENT NAME ____

THERAPY COMPANY ____

TYPE OF THERAPY ____

CASE MANAGER NAME ____

CASE MANAGER EMAIL ____

The following page outlines expectations for providers entering Mainspring Academy's campus. I understand that any deviation from these expectations will be grounds for termination of the provider agreement. I understand that all providers visiting Mainspring must agree to these terms prior to providing services on campus.

I understand that it is my responsibility to initiate communication between the clinician and the Director of School Programming, via email, at the initiation of the school year and/or start of services. Any changes in provider information should be communicated by the parent to the Director of School Programming.

Signature of Parent____**Date**____________________