



### 2025-2026 PERMISSION FOR IN-SCHOOL SERVICES

Parent Name: \_\_\_\_\_ Student Name: \_\_\_\_\_

#### THERAPY GROUP 1

Therapy Company \_\_\_\_\_

Type of Therapy \_\_\_\_\_

Case Manager Name \_\_\_\_\_

Case Manager Email \_\_\_\_\_

#### THERAPY GROUP 2

Therapy Company \_\_\_\_\_

Type of Therapy \_\_\_\_\_

Case Manager Name \_\_\_\_\_

Case Manager Email \_\_\_\_\_

#### THERAPY GROUP 3

Therapy Company \_\_\_\_\_

Type of Therapy \_\_\_\_\_

Case Manager Name \_\_\_\_\_

Case Manager Email \_\_\_\_\_

#### IN-SCHOOL SERVICES AGREEMENT

All providers are required to sign the Provider Policy Agreement and submit the information necessary for the School to confirm Level 2 background clearance before 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 School Administration, 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 School Administration.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_