613 Cook Street
Royston, GA 30662
Phone: (706) 491-5409
Fax: (888) 234-6659

**Family Participation**

By signing below, I understand that my participation in the treatment program is essential for my child's learning. I will discuss with our Program Supervisor the best way I can be involved in my child's program, taking into account our family dynamics and time constraints. I understand our Program Supervisor will recommend a set number of training hours each month that are deemed medically necessary to my child's progression. I understand that I will have to participate in the following ways:

- Working with our Program Supervisor to determine goals that are important for me to learn with regard to increasing the likelihood of a positive outcome for my child
- Attending regularly scheduled appointments designated for family training
- Ensuring that all caregivers who regularly interact with my child at home receive training, as recommended by our Program Supervisor
- Regularly practicing skills learned during family training with my child
- Openly discussing any barriers or limitations that hinder the learner and family from successfully implementing the treatment programs
- Helping my child generalize skills learned throughout the treatment program

I understand that if I have any questions or concerns regarding my child's programs I may speak to our Program Supervisor.

I understand that I may ask for additional training, if I have questions or need further assistance.

I understand that, upon request, Shining Star Therapy Services will provide additional information, guidance, and educational materials to help me best support my child's growth and development.

I understand that failure to participate in family training may decrease the likelihood of a positive outcome for my child and affect my child's future services.

_____ _____

Child Name (Print) Date

_____ _____

Parent Name (Print) Parent Signature