Sensory Gym Policies and Procedures

Carolina Therapy Connection has established a variety of policies and procedures to ensure our clients have both a fun and safe experience while participating in therapy using our sensory gym. Please review the following policies. If you have any questions regarding our policies and procedures, please contact Cindy Taylor, by email or phone: Cindy@carolinatherapyconnection.com or 252-341-9944.

- No food, drink or gum allowed in the sensory gym.
- No shoes on the mats, with the exception of shoes needed to position orthotics.
- Siblings are not allowed on any equipment if present during evaluations or treatment.
- All children and families must be accompanied by a therapist when in the gym.
- Changing table is located in front lobby restroom for all diaper changes.
- Parents are welcome to observe their child in the sensory gym; however, we ask that they remain seated in the chairs located in the gym. Use of the equipment and mats are reserved for the treating child and therapist only.

Sensory Gym Release Waiver and Assumption of Risk

I do hereby give my consent for my child to participate in the sensory gym at Carolina Therapy Connection, PC. I am fully aware that engagement in activities in the sensory gym presents a risk of injury during treatment and evaluations. I am fully aware of and appreciate the risk and damages that might occur as a result of my child's participation in or attendance at Carolina Therapy Connection. Nonetheless, I, on my own behalf of my child and our heirs, administrators and executors, do hereby release, indemnify and agree to hold harmless Carolina Therapy Connection, PC and all persons or entities associated with Carolina Therapy Connection, PC. from any responsibility or liability for any and all claims, demands, damages, costs, causes of actions and expenses (including, without limitation, reasonable attorneys' fees) arising out of or resulting from my child's participation in or involved with any therapy/evaluations, including without limitation, any personal injury, disability or property damages incurred or sustained by me or my child during or as a result of treatments/ evaluations conducted by Carolina Therapy Connection, PC. I understand that the participant's family medical insurance policy must cover any medical costs incurred in case of an accident.

I do hereby verify that I fully understand and accept the preceding conditions for permitting my child to participate in therapy/evaluations at Carolina Therapy Connection, PC.

Child's Name: _____ **Date of birth: _____**
Address: _____ **City: _____ Zip: _____**

Parent's Signature: _____ **Date:_____**