

Child Pick-up Authorization

Name: _____

Address: _____ City/State: _____ Zip: _____

Relationship: _____

Phone #: _____

Additional persons who may pick up my child/children on a less frequent basis:

Name: _____

Address: _____ City/State: _____ Zip: _____

Relationship: _____

Phone #: _____

Name: _____

Address: _____ City/State: _____ Zip: _____

Relationship: _____

Phone #: _____

Any person(S) NOT authorized to pick up my child/children:

Note: Any person unfamiliar to me will be required to show proof of identification. Under NO circumstances will the child be released to anyone other than those listed above without WRITTEN permission from the parent.

Mother's signature: _____ Date: _____

Father's signature: _____ Date: _____

Pick-up Authorization

I, _____ (parent/guardian) give permission to _____
to pick up my child, _____, from the Brent Woodall Foundation on
_____.

The above person(s) shall have authority to drop off and pick up my child from therapy.

Parent/guardian: _____ Date: _____