PERMISSION FOR RELATED SERVICES

My child _____ has permission
NAME

to see _____ for individual and/or
THERAPIST/SPECIALIST NAME

group therapy or support delivered during the school day in

Sabot at Stony Point's facility.

THERAPIST ADDRESS _____

_____

PHONE _____ EMAIL _____

PLEASE PRINT YOUR NAME _____

SIGNATURE _____

DATE _____

Please return to the Administrative Office, Sabot at Stony Point School

SABOT AT STONY POINT

3400 Stony Point Road
Richmond, VA 23235
(804) 272-1341
(804) 560-9255 fax

sabotatstonypoint.org