PERMISSION FOR RELATED SERVICES

My child ______________________________ has permission to see __________________________________
NAME THERAPIST/SPECIALIST NAME

for individual and group therapy or support delivered during the school morning in Sabot at Stony Point's facility.

SIGNED ____

PLEASE PRINT YOUR NAME ____

DATE ____

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

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

sabotatstonypoint.org