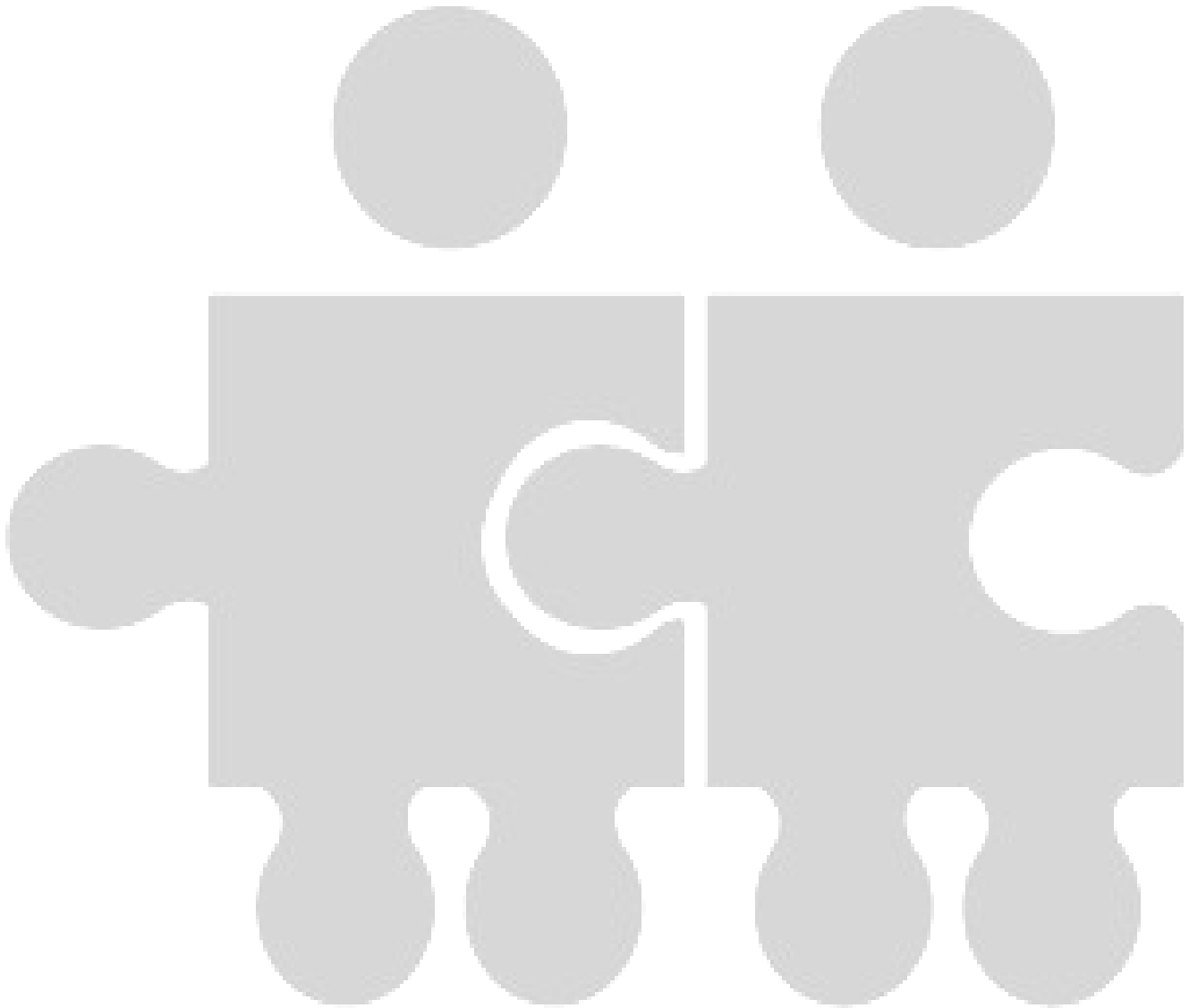


PEDIATRIC THERAPIES at COOL SPRINGS

TELL US YOUR CHILD'S SUCCESS STORY!!



Child's Name: _____ Date: _____

Caregiver's Name: _____ Relationship to Child: _____

Permission to Publish: Yes No Permission to Send to Referring Physician: Yes No

Receiving: OT PT SLT MT Therapist(s): _____