The Learning Spectrum • 125 Dillmont Drive
Columbus, OH 43235 • 614-844-5433

ENROLLMENT FORM: The C.I.R.C.L.E., APRIL 9 THROUGH MAY 14

PICK YOUR GROUP (S):

☐	Session 1 / 2	10:00 – 12:00	$300.00	(Spectrum)
☐	Session 1 / 2	10:00 – 12:00	$ 60.00	(Sibling)
☐	Session 2 / 3	10:00 – 12:00	$ 60.00	(Sibling)
☐	Session 3	10:00 – 11:00	$ 20.00	(Sibling)
☐	Session 4	11:00 – 12:00	Free	(Parent Support Group)

TOTAL $_____

Funding Source: ☐ Autism Scholarship-TLS Students Only ☐ Delaware County ☐ Private Pay

Will you be staying on campus during sessions? _____

PLEASE RETURN YOUR ENROLLMENT FORM BY WEDNESDAY, APRIL 6.
SEND ENROLLEMENTS TO: ***therapy@thelearningspectrum.com***

Name of Child: _____

Date of birth: _____ Parent Name: _____

Parent Cell Phone: _____ Parent Email:_____

Address: _____ City, State, Zip: _____

Emergency Contact Name / Number: _____

Medical Diagnosis: _____

Medications: _____

Allergies: _____

Additional notes about your child: _____

_____

I agree to pay the total amount, with the funding source as indicated above upon enrollment. I acknowledge the amount indicated is for the 6-week session that begins April 9th and ends May 14th. I understand that if my child should fail to attend any portion of this offering, there will be no refund or pro-rated amount returned to me. If TLS should happen to close due to weather related or unforeseen circumstances, an additional week will be added to the offering. If I cannot attend the additional session being offered, I acknowledge there will be no refund or pro-rated amount returned to me.

Signature: _____ Date:_____