Autism Movement Therapy

Saratoga Bridges NYSARC, Inc. is now offering Thursday Evening Classes of Autism Movement Therapy

Saratoga Bridges is pleased to offer a 6 week session of Autism Movement Therapy instructed by Kristy Cox, Medicaid Service Coordinator, and Diana Graviano, speech pathologist, who are both certified Autism Movement Therapy Level II Instructors.

Autism Movement Therapy (AMT) classes are a dance, music, and exercise based experience. AMT provides sensory integration to connect the left and right hemispheres of the brain. AMT combines patterning, visual movement calculation, audible receptive processing, and rhythm and sequencing for a "whole brain" cognitive thinking approach. AMT aims to improve behavioral, emotional, academic, social, and speech and language skills.

If your child desires to participant, please have a parent or guardian complete the attached application and return it by 9/5/13 to Patty Paduano at 16 Saratoga Bridges Blvd., Ballston Spa, NY 12020 or via email ppaduano@saratogabridges.org. For more information please call Patty @ (518) 587-0723, ext. 1254

Dates: 9/12, 9/19, 9/26, 10/3, 10/10, 10/17

Time: 4:30-5:30pm **Ages:** 6-10 years

Location: National Dance Museum
99 South Broadway
Saratoga Springs, NY 12866

Fee: $25/ per 6 week session (scholarship may be available; please contact Patty Paduano)

Please have your child dressed comfortably with sneakers.

Please have your child bring water.

There is a maximum of 10 children per class.

Parents/care provider are required to remain in the building during the duration of the class.

Autism Movement Therapy

Registration form for Autism Movement Therapy

Name of Child: Age of Child:

Name of Parent or Care Provider:

Phone number:

Email Address:

Signature of Person enrolling Participant: _____

Relationship to participant:

Questionnaire:

1. Does your child have any physical limitations?_____
2. Does your child have seizures?_____
3. Does your child have a cardiac problem? _____
4. Can you think of any reason, such as recent physical illness or chronic condition that might hinder their ability to participate safety in Autism Movement Therapy?

   _____

You will be contacted if your child has been selected to participate in the 6 week session once the registration form and questionnaire has been received. Thank you for your interest in this program!

I understand that this 6 week session of Autism Movement Therapy is presented with an emphasis on safety, non-competition & mindfulness, and have explained this to my child, who promises herein to practice mindful movement and to avoid forcing his/her body in any way in the classes. My child is participating voluntarily in this Autism Movement Therapy program and is physically able to proceed with this program. With this questionnaire/registration form I am informing the instructor of any physical limitations and/or health concerns, for which I accept sole responsibility. Additionally, I hold harmless Kristy Cox and Diana Graviano, and Saratoga Bridges, NYSARC Inc., Saratoga County Chapter, its officers, agents and employees for any liability for any personal injuries or loss of my personal property or third party claims by reason of participation in this program. I waive the rights to claims for any damages/injuries against Kristy Cox and Diana Graviano, Saratoga Bridges, NYSARC Inc., Saratoga County Chapter or the officers, agents and employees of Saratoga Bridges. Also, I understand the course fee is inclusive, and once I register no refunds will be given for classes I do not attend. I have written my e-mail address legibly here so I may be notified of any changes in the schedule.

In signing I acknowledge I have read, understand and agree to the terms detailed here, in this "Assumption of Risk" Waiver.

Signature of Parent/Guardian's Signature_____