

Autism Movement Therapy

**Saratoga Bridges NYSARC, Inc. is now offering a 4 week session
of Autism Movement Therapy**

Instructor

***Kristy Cox, Medicaid Service Coordinator, is a certified Autism
Movement Therapy Level II Instructor,
Yoga Instructor, & Barre Instructor***

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. It 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, speech and language skills.

Dates: 10/20, 10/27, 11/3 & 11/10

Time: 3:30-4:30pm

Ages: 6-10 years

**Location: Saratoga Bridges NYSARC, Inc.
16 Saratoga Bridges Blvd.
Ballston Spa, NY 12020**

**Fee: \$20 for entire session (Scholarships may be available. Inquire with
Patty Paduano.)**

Children need to be dressed comfortably with sneakers and bring a water bottle.

**With a maximum of 10 children per class, parents/care provider are required to remain in
the building during the duration of the class. There will be other assistance to help.**

**If your child desires to participant, please complete the application and return it by 10/3/14
to Patty Paduano at 16 Saratoga Bridges Blvd., Ballston Spa, NY 12020 or via email
ppaduano@saratogabridges.org. For more info, please call Patty at 587-0723, ext. 1254.**



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 safely in Autism Movement Therapy? _____

You will be contacted if your child has been selected to participate in the 4 week session once the registration form and questionnaire has been received. Thank you for your interest in this program!

I understand that this 4 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 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, 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 _____