

The
TEACHING RESEARCH
INSTITUTE

*Qigong Sensory Training 2:
Trainer Qigong and QST Dual Program*

Child Registration Form

You must complete both the Registration Form and the Authorization Form if you are paying by credit card.

Parent/Guardian Name: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Child's Name: _____ Birthday: _____

Your relationship to the child (e.g. mom, grandfather): _____

Does your child have a medical and/or educational diagnosis of autism?

_____ Medical diagnosis of autism

_____ Educational diagnosis of autism

_____ No diagnosis of autism

Does your child have any other medical problems or diagnoses?

_____ No

_____ Yes. If yes, please specify: _____

Is your child taking medications and/or supplements?

_____ No

_____ Yes. If yes, please specify: _____

Is your child receiving any other treatment for autism at this time and/or are you planning to start any new treatments in the next five months?

_____ No

_____ Yes. If yes, please specify: _____

By signing below, I certify to the truth and accuracy of the information provided on this registration form.

Signature of Parent/Caregiver

Date

Please initial each of the following statements to signal your agreement and understanding of the responsibilities you will have as a parent/caregiver of the child receiving treatment:

_____ I agree to attend all sessions, as follows. Except for the parent training, all sessions will be held in Portland, Oregon. (Please initial your ability and willingness to attend appointments on each date.)

_____ October 3 from 2:00-5:00 – Parent training IN SALEM (for parents/caregivers only)

_____ October 9 or 10 – First treatment appointment (45 minutes)

_____ October 16 – Treatment appointment (30 minutes)

_____ October 23 – Treatment appointment (30 minutes)

_____ October 30 – Treatment appointment (30 minutes)

_____ December 4 – Treatment appointment (30 minutes)

_____ December 18 – Treatment appointment (30 minutes)

_____ February 12 – Exit interview (30 minutes)

_____ I agree to attend 14 additional, 30-minute treatment sessions, as scheduled with my QST therapist.

_____ I agree to complete the pre- and post-test surveys for my child

_____ I have reviewed and signed the attached consent form.

Registration Fee: \$325 per child

Method of Payment (check one):

Check (Payable to: Teaching Research Institute)

Credit Card (complete Authorization Form)

Refunds of the full registration fee will be honored up to two weeks before the start of the parent training. After that date, refunds will not be given.

Questions? Please contact Kris Gabrielsen at kris@qsti.org or 503.474.0218

PLEASE SEND ONE FORM PER CHILD, WITH PAYMENT TO:

Cindi Mafit • Teaching Research Institute • Western Oregon University

345 N. Monmouth Avenue • Monmouth, OR 97361

Or fax to 503.838.8812

The
TEACHING **R**ESEARCH
INSTITUTE

Credit Card Authorization Form

You must complete both the Registration Form and the Authorization Form if you are paying by credit card.

Please charge my credit card in the amount of \$ _____ for my child's registration to the *Qigong Sensory Training 2: Trainer Qigong and QST Dual Program training*.

Name of registration attendee: _____

BILLING INFORMATION:

Your name (as it appears on your credit card): _____

Type of credit card: Visa MasterCard Discover

Credit Card #: _____ - _____ - _____ - _____

Security Code (3-digit code on back of card): _____ Expiration Date (mm/yy) _____ / _____

BILLING ADDRESS:

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Telephone: _____

Cardholder's Signature: _____ Date: _____

PLEASE SEND ONE FORM PER PERSON, WITH PAYMENT TO:

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INFORMED CONSENT FOR PARENTS OF YOUNG CHILDREN ON THE AUTISM SPECTRUM TO PARTICIPATE IN A QIGONG SENSORY TRAINING PROGRAM

The Teaching Research Institute at Western Oregon University is engaged in training and on-going research in a non-invasive intervention for children on the autism spectrum - Qigong Sensory Training (QST).

Research using Qigong Sensory Training shows it can be helpful for young children on the autism spectrum with sensory impairment: both in relieving their sensory impairment and in helping them to learn better. You are beginning an eighteen week program of training and treatment with your therapist and are being asked to sign this consent to signal that you understand the program and its requirements, and give consent for you and your child to participate.

Your therapist will ask you to fill out several questionnaires before and after the training and treatment program which will be useful to both of you in documenting change in your child, as when you live with your child every day, sometimes even big changes do not get noticed.

At the end of the training, your therapist will meet with you, show you the results of pre and post testing, and give you a recommendation for how long you should continue the home program.

This is a gentle touch therapy and does not involve risk of harm, for children or parents, if it is correctly done. You will receive ample instruction in the therapy, and be tested on whether you are giving it correctly. If you drop out of the program early, or do not comply with it as instructed below, there is a risk that your child may not receive the full benefit of the therapy.

Some of your sessions with Dr. Silva or the trainer will be videotaped for research and training purposes. Videotapes will be kept in a locked cabinet at Dr. Silva's office.

We ask several things of you if you decide to begin this program:

1. During the 18 weeks of the program, you must be willing and able to give the child the daily massage treatment lasting about 15 minutes.
2. We prefer that you not begin any new therapies for autism during the time that your child is in the program. If it becomes necessary to do so, we ask you to let us know the type of therapy, and when it is begun.
3. You will need to be willing and able to transport your child to get treatment from the therapist a total of 20 times. Treatment by the therapist is twice a week for five weeks, followed by a month off and then another cycle of treatment twice a week for five weeks.
4. If you miss appointments, they will be rescheduled. If you are consistently not able to bring your child to be treated, it may be necessary to drop your child from the training.

I have read the above information and agree to participate in this training program. I understand that I may withdraw at any time and that information gathered will be used in the manner described above. On behalf of my child and myself, I agree to the videotaping, and I release full ownership of the videotapes to Dr. Silva. I understand that these videotapes may be used in future trainings of parents and therapists.

Participant Signature

Child's Printed Name

Participant Printed Name

Date