2024 Acknowledgement and Receipt of the Partners For Progress Client/Parent/Guardian/Spouse Handbook

I acknowledge that I have received a copy of the Partners For Progress Client/Parent/Guardian/Spouse Handbook. I understand that it contains important information on policies and procedures. I realize this handbook is not intended to cover every situation that may arise but is a general guide to refer to.

I understand that it is my responsibility to familiarize myself and my child(ren) with the information and I agree with the policies and rules of the program.

I further understand and acknowledge that Partners For Progress may change, add, or delete any policies or provisions in this handbook as they see fit in its' sole judgement and discretion.

I acknowledge and understand that this handbook supersedes and replace any and all prior handbooks or materials previously distributed.

Client Name (please print): _____

Client Signature: _____ Date:_____

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date:_____

2024 Client Registration and Liability Release Forms

Client First Name: _____ Last Name: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

County: (used for grant purposes) _____

Ethnicity of Rider: (used for grant purposes only)

____ Caucasian ____ Middle Eastern
____ African American / Black ____ Pacific Islander
____ Hispanic / Latino ____ Native American / Alaskan
____ Asian ____ Other: _____

Year Started Riding at Partners For Progress: _____

Parent(s)/Spouse/Guardian(s) _____

Address if different from above: _____

Email: _____ 2nd Email:_____

Primary Phone: _____ Alternate:_____

Employer Name: _____

Employer City/State/Zip: _____

Medical Information in case of Emergency: _____

Parent(s)/Spouse/Guardian(s) _____

Address if different from above: _____

Email: _____ 2nd Email:_____

Primary Phone: _____ Alternate:_____

Employer Name: _____

Employer City/State/Zip: _____

Medical Information in case of Emergency: _____

Names of those that may accompany rider to the farm:

1. Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Relation to Rider:_____ Able to pick-up Rider? _____Yes _____No

Medical Information in case of Emergency:_____

2. Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Relation to Rider:_____ Able to pick-up Rider? _____Yes _____No

Medical Information in case of Emergency:_____

3. Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Relation to Rider:_____ Able to pick-up Rider? _____Yes _____No

Medical Information in case of Emergency:_____

4. Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Relation to Rider:_____ Able to pick-up Rider? _____Yes _____No

Medical Information in case of Emergency:_____

5. Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Relation to Rider:_____ Able to pick-up Rider? _____Yes _____No

Medical Information in case of Emergency:_____

If independent, adult rider with no spouse:

Emergency Contact Name: _____

Relationship to Client: _____

Emergency Contact Phone: _____

Emergency Contact Email: _____

Medical Information in case of Emergency: _____

Alternate Emergency Contact Name: _____

Relationship to Client: _____

Secondary Emergency Contact Phone: _____

Emergency Contact Email: _____

Medical Information in case of Emergency: _____

LIABILITY RELEASE

Read Thoroughly Before Signing

Note: A Separate Form Must Be Signed For Each Participant.

I/We would like to participate in the Partners For Progress NFP and/or Pediatrics In Motion programs. I/We acknowledge that therapeutic and pleasure horse riding is a dangerous activity which incorporates potential risks to myself/my son/my daughter/my ward, the horse that is ridden, the equipment that is used, or other equine/animal interactions in a farm setting. I/We feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed.

Therefore, with this knowledge, intending to be legally bound for myself, my heirs and assigns, executors or administrators, I/We hereby waive, discharge, indemnify, hold harmless, and release forever all claims for damages against Partners For Progress NFP and Pediatrics In Motion, its' Board of Directors, Officers, employees, instructors, therapists, aides, and volunteers, their heirs, executives, administrators, successors, or assigns from any and all liability for any and all injuries, damages, and/or losses sustained by me/my daughter/my son/my ward, any animal owned or controlled by me, or for any item or personally under my dominion and control while participating in a Partners For Progress NFP and/or Pediatrics In Motion program. This includes attorneys' fees and cost of suit in any action based upon or arising from my/my sons'/my daughters'/my wards' acts or omissions, or the actions of any animal with my/my sons'/my daughters'/my wards' control.

WARNING: Under the Equine Activity Liability Act, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risk of equine activities. ~IL PWA-89-0111~

I acknowledge that I have read the foregoing and understand the contents thereof.

Client Name (please print): _____

Client Signature: _____ Date:_____

Minors must have the following signed by their Parent or Legal Guardian:

I, the undersigned parent or legal guardian named here (please print) _____ _____ of the Client name here (please print) _____ for and in consideration of our childs'/wards' participation at Partners For Progress and Pediatrics In Motion, and any other minors' listed above in numbers 1 through 5 that may accompany said rider to the farm, state that I have read the LIABILITY RELEASE statement written above, and I expressly agree that warrant I have health and accident insurance for said minor(s).

Signature_____ Date_____

As an adult (over age 18) that may accompany said rider to the farm listed above in numbers 1 through 5 that may/or may not be allowed to pick-up said rider from the farm, I also acknowledge that I have read the foregoing and understand the contents thereof.

Name (please print): _____
Signature: _____ Date_____

Name (please print): _____
Signature: _____ Date_____

Name (please print): _____
Signature: _____ Date_____

Name (please print): _____
Signature: _____ Date_____

Name (please print): _____
Signature: _____ Date_____

2024 Client Health History Form

Client Name: _____

Current Height: _____ **Current Weight:** _____
Please be as accurate as possible as this affects the needs of our horses. Thank you.

Diagnosis & Date of Onset (please list all relevant): _____
_____

Medications (include dosage) that the Client is currently taking, including any over the counter medications:
_____
_____

Any hospitalizations and/or surgeries within the last year? _____ Yes _____ No
If yes, please comment:
_____
_____
_____

Please indicate current or past challenges in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Allergies			
Auditory/Hearing			
Behavioral			
Bone/Joint			
Breathing			
Cardiac/Heart/Pulmonary			
Circulatory			
Communication			
Digestion			
Elimination			
Emotional/Psychological			
Learning Disability			
Mental Impairment			
Muscular			
Neurological			
Orthopedic			
Pain			
Sensation			
Speech			
Thinking/Cognition			
Visual			
Other			

SEIZURES: _____ Yes _____ No If yes, please see Seizure Protcol Form.

FOR PERSONS WITH DOWN SYNDROME:
Cervical X-Ray for AtlantoAxial Instability: Postive_____ Negative_____ X-Ray Date: _____

MOBILITY: (i.e. mobility skills such as walking, wheelchair use, transfers, driving/bus riding, etc.)

_____
_____
_____

FAMILY: (please share information on any siblings or other family members important to the Client)

_____
_____
_____

SOCIAL: (i.e. work, school including grade completed, leisure interests, relationships – family structure, support systems, companion animals, fears/concerns, etc.)

_____
_____
_____

OTHER: Are there any other physical, emotional, or cognitive changes that have occurred in the last year? If yes, please describe. Please provide any other information that will enhance the Clients' lesson.

_____
_____
_____

GOALS: (i.e. what would the Client like to accomplish)

_____
_____
_____

I attest that this information is accurate (to the best of my knowledge). Partners For Progress NFP and Pediatrics In Motion reserve the right to require an annual Medical History and Physician's Statement from any client.

I agree to release, indemnify, and hold Partners For Progress NFP and/or Pediatrics In Motion (and its' officers, directors, instructors, therapists, employees, aides, and volunteers) harmless from any injury or loss arising out of any inaccurately reported or omitted medical information.

Client Name (please print): _____

Client Signature: _____ Date:_____

Minors must have the following signed by their Parent or Legal Guardian:

I, the undersigned parent or legal guardian named here (please print) _____ of the Client name here (please print)_____ for and in consideration of our childs'/wards' participation at Partners For Progress and Pediatrics In Motion, state that I have read the statement written above.

Signature _____ Date_____

SEIZURE PROTOCOL FORM

(Complete this form only if applicable)

Seizure Type: _____

Date of Last Seizure: _____

Medications: _____

Frequency of Seizures: _____

Controlled: _____ **Yes** _____ **No**

What do the seizures look like?

_____
_____
_____
_____
_____
_____

If you or your child/ward has a seizure while at Partners For Progress NFP and/or Pediatrics In Motion, are there any special actions or procedures you would have us follow?

_____
_____
_____
_____
_____
_____

Client/Parent/Guardian Signature: _____

Print Name: _____ **Date:** _____

***** Please Note: We are not able to administer medications. If a seizure occurs while the Client is at Partners For Progress NFP and/or Pediatrics In Motion and a parent/guardian is not available or on site, we reserve the right to call emergency services.**

2024 Client Medical History & Physician's Statement

Dear Physician,

Your patient, _____ would like to participate in equestrian activities at Partners For Progress NFP and/or Pediatrics In Motion. To do so they need an updated medical status. Please review their current medical status and complete the following information. Partners For Progress NFP and/or Pediatrics In Motion does not require an office visit for this update. Please address occurrences over the past year including surgeries, illnesses, hospitalizations, changes in medications, treatment, weight, or behavior. Please include current height and weight.

Client First Name: _____ Last Name: _____

Height: _____ Weight: _____ F _____ M _____ Date of Birth: _____

Diagnosis: _____

Date of Onset: _____

Cause: _____

Medications (type, purpose, dosage): _____
_____
_____

SEIZURES?: _____ Yes _____ No Type: _____ Controlled?: _____ Yes _____ No
Date of last knowns seizure: _____

Shunt Present: _____ Yes _____ No Date of Last Revision: _____
Special Precautions/Needs: _____
_____
_____

MOBILITY:
Independent Ambulation: _____ Yes _____ No Assisted Ambulation: _____ Yes _____ No
Wheelchair: _____ Yes _____ No Braces/Assistive Devices: _____ Yes _____ No
_____

Tetanus Shot: _____ Yes _____ No Date: _____

Past/Prospective Surgeries: _____
_____

Please indicate any special precautions: _____
_____

Please indicate current or past special needs in the following systems/areas including surgeries (these conditions may suggest precautions and contraindications to equine activities):

Areas	Yes	No		Areas	Yes	No
Allergies				Integumentary/Skin		
Auditory/Hearing				Learning Disability		
Balance				Mental Impairment		
Behavioral				Muscular		
Bone/Joint				Neurological		
Breathing				Orthopedic		
Cardiac/Heart/Pulmonary				Pain		
Circulatory				Scoliosis – Degree/Type		
Cognitive				Sensation/Sensory		
Cranial Defects				Skeletal		
Communication				Speech		
Digestion				Spinal Column Abnormalities		
Elimination				Spinal Column Injuries		
Emotional/Psychological				Tactile		
Fractures-Location/Healed				Thinking/Cognition		
Heterotopic Ossification				Visual		
Immunity				Other		

Comments: _____
_____
_____
_____

Please indicate any medical problems not listed above: _____
_____
_____

Please provide any other information that might help us work with this client: _____
_____
_____

FOR PERSONS WITH DOWN SYNDROME:

Cervical X-Ray for AtlantoAxial Instability: Postive_____ Negative_____ X-Ray Date: _____
X-Ray for AtlantoDens Interval: Postive_____ Negative_____ X-Ray Date: _____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the PATH International Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH International Center (Partners For Progress NFP) and/or Pediatrics In Motion for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ **MD DO NP PA**
Signature: _____ **Date:** _____
Address: _____
Phone: _____ **License/UPIN Number:** _____

2024 Consent For Release of Information

Periodically Partners For Progress NFP and/or Pediatrics In Motion may want to consult with other agencies/therapists with which you are working. Please provide their name(s) and address(es) below.

I hereby authorize _____

Person(s) or facility – please list all associated with the Client with complete address and phone number
Can include, but not limited to, Prescribing Physicians, Primary Care Physicians, Specialists, Schools, Alternative Care Givers, etc.

_____
_____
_____
_____
_____
_____

to release information from the records of _____.

The information is to be released to Partners For Progress and/or Pediatrics In Motion for the purpose of developing a therapeutic riding program and/or animal assisted learning program for the above named client. The information to be released is marked below:

_____ Medical History
_____ Physical Therapy evaluation, assessment, and program plan
_____ Occupational Therapy evaluation, assessment, and program plan
_____ Speech Therapy evaluation, assessment, and program plan
_____ Mental Health Therapy evaluation, assessment, and program plan
_____ Individual Habilitation Plan (I.H.P.)
_____ Classroom Individual Education Plant (I.E.P)
_____ Cognitive-Behavioral evaluation, assessment, and/or management plan
_____ Other _____

This release is valid for one year and can be revoked in writing at my request. Please send materials to the address listed below:

Partners For Progress NFP
Pediatrics In Motion
23525 W.Milton Road
Wauconda, IL 60084
Fax: 847-438-5401
Email: info@partnersforprogressnfp.org
Email: pediatricsinmotionbilling@gmail.com

Signature _____ Date_____

Relationship to Client: _____

2024 Notice of Information Practices and Privacy Statement

Partners For Progress NFP
Pediatrics In Motion
23525 W.Milton Road
Wauconda, IL 60084
Fax: 847-438-5401
Email: info@partnersforprogressnfp.org
Email: pediatricsinmotionbilling@gmail.com

How We Collect Information About You
Partners For Progress NFP (PFP) and Pediatrics In Motion (PIM) and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voicemails, and from the submission of applications that are either required by law or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information:
Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that are considered patient confidential, restricted by law, or specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information:
Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between PFP, PIM, and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to verify your medical information is accurate and determine the type of medical supplies or health care services you need. This includes, but is not limited to, or to obtain or purchase, any type of medical supplies, devices, medications, or insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect:
We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for counters in our website analytics that simply records the number of visitors and no other data.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources:
Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of PFP and/or PIM. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without the client's express advance permission. You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Following is a Photo and Media Release Form that must be signed by Client or Client parent/guardian:

2024 Client/Parent/Spouse/Guardian/Caregiver Photo/Media Release

NOTE: A separate form must be completed for <u>each</u> Client.

I, _____ DO or DO NOT
(please print) (please circle one)

hereby grant irrevocable and unlimited consent to the use and reproduction by Partners For Progress NFP and/or Pediatrics In Motion, its' assigns, licensees, and legal representatives, of any and all photographs and any other audio/visual materials taken of me, my child or my ward, in all forms and media (including but not limited to printed media, digital media, audio media, social media, web sites, video, and audio productions). The materials may be reproduced in all forms including composite, altered, or derivative works, for promotional materials, educational activities, fundraising events, exhibitions, research materials, grant materials, or for any other lawful use for the benefit of the program.

I hereby waive the right to inspect and approve the finished version(s), including any copy that may accompany the materials. I hereby release Partners For Progress NFP and/or Pediatrics In Motion, and its Board of Directors, officers, employees, instructors, therapists, aides, assigns, volunteers, licensees, and legal representatives from all claims and liability to said materials. I sign this release as a person with, or the parent or guardian of, a person with special needs, understanding that use of these materials will make them available to the general public.

I have read and understand the above release, <u>am over 18</u>, and have the capacity to sign this release of my own free will.

Signature: _____ Date: _____

<u>OR:</u>

I am the parent/spouse/guardian of the Client named above and have the legal authority to execute the above release for the Client, as well as those listed below. I approve the foregoing and waive any rights in the premises.

Signature: _____ Date: _____

Printed name of Parent/Spouse/Guardian and minor children, who may be photographed when accompanying the Client to the farm:

_____
_____
_____
_____

2024 Billing Information and Auto-Payment Release

Partners For Progress NFP (PFP) conducts 5, 10-week Sessions per year (please see current calendar for dates of each Session). Invoices are emailed approximately two weeks prior to each Session. Payment is due prior to the start of the Session, but no later than 7 days after the start of each Session. If payment is not received by that time, a $50 Late Fee will be applied to the appropriate Sessions' invoice.

All Clients, or Client Parent/Spouse/Guardian must provide a credit or debit or FSA/HSA card to be retained on file. This card will only be used to process payment of your Session Invoices and Yearly Registration Fee.

Please complete the following billing contact information:

Name of Contact for Billing: _____

eMail Address: _____

Phone Number: _____

Name on Card: _____

Account Number: _____

Expiration Date: _____ Security Code: _____

FSA/HSA Card: ____ Yes ____ No Credit Card: ____ Yes ____No Debit Card: ____ Yes ____ No

eMail to notify of charge: _____

Is Billing Address for Card the same as Client Address: _____ Yes _____ No

Billing Address for Card if NOT the same as Client Address:

_____

_____

PFP offers an optional Auto-Pay Process. If you would like your card charged automatically when Session fees are due, please complete the information below. An additional charge of 4.0% will be added to each charge to cover card processing fees (i.e., charge of $24. for a $600 invoice). No additional charges will be paid with this card outside of the lesson fees and yearly registration fee unless you are notified.

I, _____ (card holder) acknowledge that Partners For Progress NFP is authorized to use this card to pay Session and Registration Fees and/or Pediatrics In Motion is authorized to use this card to pay medical deductibles and/or co-pays and/or co-insurance on behalf of _____ (Client). I acknowledge this agreement is good through the end of this riding season or sooner if I/We no longer participate in the programs.

Signature of Card Holder: _____

NOTE: Pediatrics In Motion (PIM) emails statements at the beginning of every month. Payment is due upon receipt. Please review the PIM paperwork for additional information.

2024 Client Financial/Fundraising and Weather Policy Confirmation

I/We have read and agree to abide by the financial policies as outlined in the Client Handbook. I understand that payment is due as stated on the invoice or statement, and that lesson fees are charged even if the Client cancels a lesson for any reason.

If payment is not made, and I do not communicate with the office regarding a payment plan, the Client may lose their riding slot.

I/We have read and agree to follow the weather cancellation policy as detailed in the Client Handbook.

All Clients at Partners For Progress NFP are considered to be participating on partial rider assistance. In order to help offset costs, we ask each Client to be a part of our fundraising team by participating in our 2 largest fundraisers – the Annual Plop O'Gold Raffle and the Annual Hoedown Gala.

The Annual Plop O'Gold Raffle is our spring event that requires the Client to sell (or purchase) 40 raffle tickets at $10.00 each. The office will distribute the necessary raffle tickets for the event.

The Annual Hoedown Gala is our fall event that requires the Client to participate in the items needed to create the raffle baskets and silent auction items. The office will communicate with you regarding the needed items and volunteer opportunities.

If you choose to participate in the fundraising, the Session Fees will be $60.00 per ride. If the Client rides once per week during a 10-week Session, the Session cost is $600.00. If you choose to fundraise and do NOT participate, you will be billed for the financial commitment.

If you choose to opt out of participating in the fundraising, the Session Fees will be $75.00 per ride. If the Client rides once per week during a 10-week Session, the Session cost is $750.00.

Pediatrics In Motion Clients are also asked to be part of the fundraising team as well. If a Pediatrics In Motion Client choses to opt out of fundraising, a $250.00 horse usage fee will be charged at the time of each Partners For Progress NFPs' scheduled Session (5 Sessions x $250.00).

Please indicate below which choice you prefer. You <u>MUST</u> choose an option. If you do not choose, you will automatically be billed at $75.00 per ride/$750.00 per Session:

_____ I choose to be a part of the fundraising team and participate in the Annual Plop O'Gold Raffle and the Annual Hoedown Gala. I understand my Sessions Fees will be $60.00 per ride, or $600.00 per Session.

_____ I choose to opt out of the fundraising team. I understand as a PFP Client that my Sessions Fees will be $75.00 per ride, or $750.00 per Session. IF I am a Pediatrics In Motion Client, I understand that I will be charged a $250.00 horse usage fee at the time of each Partners For Progress scheduled Session.

Signature: _____ Date: _____

2024

Schedule of Events

Partners For Progress, NFP

challenging therapy that's changing lives…..

SESSIONS

1: January 2 - March 9
2: March 11 - May 18
3: May 20 - July 27
4: July 29 - October 12
5: October 14 - December 21

EVENTS

April 13 - One Lucky Night Dance & Raffle Event
July 20 - Family Summerfest & Student Horse Show
TBD - Summer Camps, Job Skills
September 14 - Hoedown Gala

Start of Session

Event

No Riding

January

S	M	T	W	T	F	S
	⊘	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

March

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

April

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22.	23	24	25	26	27
28	29	30				

May

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	⊘	28	29	30	31	

June

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

July

S	M	T	W	T	F	S
	1	2	3	⊘	⊘	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September

S	M	T	W	T	F	S
1	⊘	3	4	5	6	7
8	9	10	11	⊘	⊘	⊘
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	⊘	⊘	30

December

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
⊘	⊘	⊘	⊘	⊘	⊘	⊘
⊘	⊘	⊘				

partners for progress

pediatrics in motion