

THRIVE DAY HABILITATION
Alternate Pick-Up Authorization Form

Consumer Name:	
Date of Birth:	DDD ID #:
ALTERNATE PICK UP PERSON (1)	
Name:	
Phone #	Relationship:
Notes:	
ALTERNATE PICK UP PERSON (2)	
Name:	
Phone #	Relationship:
Notes:	

Please note that we will ask your alternate pick-up individual (s) for identification the first time they come to Thrive.

Applicant Signature (if applicable) : _____

Caregiver/ Guardian Name (please print): _____

Caregiver/ Guardian Signature: _____

Today's Date: _____