

The Autism Project Participant Application Form



PARTICIPANT INFORMATION

Participant's Name _____

Age _____ Birthdate ____ / ____ / ____ Gender _____ Grade _____

Primary Disability/Diagnosis _____

Medical Conditions (Seizures, Asthma, Etc) _____

Further Information (Warning Signs/Duration) _____

Are there any Dietary Restrictions/Allergies? Yes _____ No _____

Further Information _____

Please list current medications and possible side effects _____

Does child require medication during program hours? Yes _____ No _____

***If yes, a medication form is required to be completed in entirety.

FAMILY INFORMATION

Primary Guardian's Name _____

Primary Address _____

Home Phone # _____

City _____ Zip _____

Primary Cell # _____

Primary Work # _____

Secondary Guardian's Name _____

Secondary Cell # _____

Primary Email _____

Secondary Email _____

PRIMARY Contact Name and Number for this participant during program hours

EMERGENCY CONTACTS

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Please give the names of any individuals authorized to pick up the participant **other** than yourself and please be aware that our staff is required to ask to see ID for verification.

1. _____

2. _____

CURRENT SERVICES INFORMATION

School Name _____
 School Address _____ City _____
 Teacher's Name _____ Phone # _____

Current Therapy/Service Providers Names and Contact Information

Doctor _____ Phone # _____
 OT _____ Phone # _____
 PT _____ Phone # _____
 SLP _____ Phone # _____
 Other Providers _____

Communication

Participants Primary Means of Communication	Please mark appropriate response	Comments
Speech is Clear/Talks in Complete Sentences		
Speech is Difficult to Understand		
Uses Short or One Word Phrases		
Nonverbal		
Uses Sign Language/Gestures		
Uses PECS		
Uses AAC Device		
Other		

Best Method of Assistance

Please Check All that Apply							
<input type="checkbox"/>	Follows Directions	<input type="checkbox"/>	Verbal Prompts	<input type="checkbox"/>	Peer Buddy	<input type="checkbox"/>	Modeling/Demonstrations
<input type="checkbox"/>	Visuals/Pictures	<input type="checkbox"/>	Gesture Prompts	<input type="checkbox"/>	Physical Prompts	<input type="checkbox"/>	Hand Over Hand
<input type="checkbox"/>	Equipment/Adaptations	<input type="checkbox"/>	Other				
<u>Comments:</u>							

Activities of Daily Living

Please mark appropriate response	Independent	Requires Some Assistance	Requires Full Assistance	Comments
Eating				
Awareness of Dietary Restrictions				
Dressing/Undressing				
Toileting				
Reading				
Writing				
Other				

Safety

Please mark appropriate response	Independent	Requires Some Assistance	Requires Full Assistance	Comments
Stay with Group				
Communicates Name and Phone #				
Responsible for Own Belongings				
Recognizes Danger				
Manages Money				
Swimming Ability				
Toleration of Band-Aids or Wristbands				
Other				

Behaviors

Does Participant Exhibit Behaviors Below?	Please mark appropriate response	Comments
Withdrawn/Shy/ Easily Discouraged		
Hyperactive		
Short Attention Span/Easily Distracted		
Runs Away/Elopes		
Aggressive-Bites/Scratches/Hits/Kicks		
Harms Self		
Displays Strong Fears (Explain)		
<u>Please name some Motivators for your Camper?</u>		
Is there a behavior plan in place? Yes ___ NO ___ If so please attach a copy		

Please give a brief description of behavior management and methods used at home/school so our staff may be consistent in behavior management techniques for your child: _____

Please Describe Sleep Patterns _____

Please Describe Eating Patterns _____

Recreation

Participant enjoys the following: Please Check All that Apply							
	Swimming		Games		Community Outings		Sports
	Video Games		Arts and Crafts		Music		Other
<u>Comments:</u>							

Socialization

Please Check All that Apply					
	Interacts with Peers		Does not Interact with Adults		Prefers to be Alone
	Does not Interact with Peers		Enjoys being with a Group		Tolerant of Loud Noises
	Interacts well with Adults		Prefers Small Groups		Does Not Tolerate Loud Noises
<u>Comments:</u>					

Please list any special talents or interests _____

What is your main goal for your child attending TAP?

Medicaid Information

Medicaid Number _____ Effective Date _____
Service Coordinator _____ County _____

Signature _____ Date _____

All Provided Information is Confidential and will Only be shared with TAP Staff