CARES Educational Services Clinic
Registration Form

Program Participant

Last Name: ______________________________ First Name:___________________________________

Date of Birth: ____________ Grade level: _________Type of Autism:____________________________

Home address: ____

Program Selection

Individual (1:1) or Social Skills Group: ____

Times/Dates you wish to attend:____

Description of your goals for the summer: ____

Parent or Guardian

Name(s): ________________________________ Home phone: (   )______________________________

Work/Cell phone: (   )_______________________ E-mail address: ______________________________

Address (if different from above): ____

What is the best way to reach you?____

Emergency Contacts

(1) Name(s): ____ Relationship to child? _______________

Home phone: (   )________________________ Work/Cell phone: (   )______________________________

(2)Name(s): ____ Relationship to child? _______________

Home phone: (   )________________________ Work/Cell phone: (   )______________________________

Health Information

Participant's Physician: _________________________Phone:______________________________________

Clinic: __________________________________Address:____

Special medical needs or concerns:____

Medical Release

I authorize emergency medical treatment for my child, ________________, in the event that a parent/guardian or emergency contact cannot be reached in a timely manner.

Printed Name:____

Signed: ___________________________________ **Date:** ______________________________

CARES Educational Services Clinic

Pre-Assessment

PROGRAM PARTICIPANT

Participant: ______________________________________ Date of Birth: _______________ Grade level: __________

PARENT OR GUARDIAN

Name(s): ____ Home phone: (   )________________________________

Work/Cell phone: (   )_____________________________ E-mail address: ___________________________________

Address: ____

PARTICIPANT INORMATION

1. What types of activities and items does your child enjoy?

   a. Indoor: ____
   b. Outdoor: ____
   c. Community: ____
   d. Food: ____
   e. Music: ____
   f. Toys: ____
   g. Rewards: ____
   h. Social activities: ____________________________________
   i. Other: ____
   ____

2. What types of activities and items does your child NOT enjoy or have difficulty performing/attending to?

   ____

3. How does your child typically communicate with others *(check all that apply)?*

   ___ Verbal ___ Picture system ___ Points to desired object

   ___ Assistive technology (AT) device ___ Sign Language ___Other (please specify) _________

4. Briefly list some of your child's strengths:

   ____

5. Mark the top three skill areas that you would like to see your child learn or improve while in this program. *(Indicate with a 1, 2, 3)*

   ___ Behavior ___ Social skills ____ Vocational

   ___ Communication ___ Self-help ____ Recreation/leisure

   ___ Academics ___ Functional routines ____ Transitions

6. Briefly describe the educational techniques used with your child to date and which you think were the most successful.

   ____

7. Has your child received ABA therapy services before? ____ Yes ____ No

   If so, who provided these services and the duration of the services: ______________________ ___________________

8. Describe your child's school program and any other pertinent information *(can use the back if needed)?*

   ____