CARES Educational Clinic
Information Waitlist Form

TEXAS STATE UNIVERSITY
The rising STAR of Texas

Program Participant

Last Name: _____ First Name:_____

Age: _____ Grade level: _____Type of Autism:_____

Home address: _____

Parent or Guardian:

Name(s): _____ Home phone: ( )_____

Work/Cell phone: ( )_____ E-mail address: _____

Behavors you are concerned with or want to address:

_____

_____

_____

_____

_____