



Autism/Asperger's Group Social Skill Enrichment

Date: _____

Name: _____

Gender: _____

DOB: _____

Grade Level: _____

Diagnosis: (List all) _____

Private Insurance: Yes No (If yes, and child is between the ages of 8 and 10, complete insurance verification form. We will attempt to secure insurance reimbursement on your behalf.)

Scholarships/Tuition Assistance: Please provide your tax return if interested in reduced fees.

Parent/Guardian: _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: _____ **E-Mail:** _____

Emergency Contact Name and Number: _____

Services Requested: Check all that apply

- Social skills group 8-10 years
- Social skills group 11-15 years
- Individual behavior treatment

Does your child have any of the following? (Check all that apply).

	Yes	No	Describe
Seizures			
Visual Impairment			
Hearing Challenges			
Special Diet			
Other Impairment (describe)			

Medications: (List all) _____



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Likes and Dislikes:

List preferred items, activities and foods:

List non-preferred items, activities, and foods:

Does your child like dogs? _____ If no, please explain. _____

Behavior Information

Behavior	Yes	No	How often does the behavior occur (daily, weekly, etc)
Physical Aggression			
Verbal Aggression			
Property Destruction			
Non-compliance			
Aggression towards self			
Unauthorized Departure			
Pica (eating of inedible objects)			
Inappropriate sexual behavior			
Other			

Does your child have a Behavior Intervention Plan in place: Yes No (If yes, please provide copy)

Does your child have an Individual Educational Plan (IEP) in place: Yes No (If yes, please provide copy)



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Social Skills:

How does your child interact with others?

Does your child (check all that apply):

- Play alone
- Take turns
- Have difficulty participating in a group
- Require prompting to interact with others
- Resist when asked to interact with others
- Engage in perseverative/repetitive behaviors
- Interact in a parallel manner (beside another child and engage in same activity)
- Become upset when others do not play the way he/she intended

Sensory Information:

Does your child have any sensory sensitivities? Please describe.

What areas of improvement would you like to see in your child by the end of this class?

We would like to have at least one teacher or therapist reference. Please complete the form on the next page to facilitate us obtaining a reference. Please return form to Debi@AustinDogAlliance.org or fax to (512) 287-4880 or mail to 12129 Ranch Road 620 North, Ste. 401, Austin, TX 78750. We look forward to working with your child.



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NOTICE OF RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Student's Name	Date of Birth	School	Grade
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I, the parent/guardian of the child named above, authorize the agency named below to release confidential information regarding my child to Austin Dog Alliance's K9 Club Autism/Asperger's Group Social Skills Program staff. By signing below, I understand that the purpose of this disclosure is to determine my child's participation in the Austin Dog Alliance K9 Club Autism/Asperger's Group Social Skills Program. I also understand that the information requested by Austin Dog Alliance may include discussion of the following: behavior in structured and unstructured settings and staff support needed in these areas, IEPs, FBA/BIP, special accommodations and/or modifications, and any other information my child's teachers/therapists feel may be pertinent to my child's success in the K9 Club Program.

<u>Agency to Release Information:</u>			
Name and Position		School/Agency	
City	Zip	Phone	Fax

Parent/Guardian Signature	Date
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