



Asperger's Friends Network

**Autism Society Ontario – Halton Chapter
2003**

Family Information

Father:

Salutation: Mr. Dr. Other

Last Name: _____

First Name: _____

Home Tel: _____

Bus. Tel: _____

Cell Tel: _____

Pager: _____

Fax #: _____

E-mail: _____

Occupation: _____

Mother:

Salutation: Ms. Mrs. Dr. Other

Last Name: _____

First Name: _____

Home Tel: _____

Bus. Tel: _____

Cell Tel: _____

Pager: _____

Fax #: _____

E-mail: _____

Occupation: _____

Mailing Address of Family:

Street: _____

City: _____ Postal _____

Back Up Contact: (if above can't be reached):

Name: _____

Telephone: _____

Relationship: _____

Transportation Information:

Who will regularly drop off child?: Dad Mom Other: _____
pick up child?: Dad Mom Other: _____

Other adult with permission to drop off/pick up:

Name: _____ Tel: _____ Relationship: _____

Basic Medical Information:

Doctor's Name: _____

Doctor's Telephone: _____

Doctor's Address: _____

OHIP # _____ Version Code (if applicable): _____

Background Information

School Attends: _____ Last grade completed: _____

Special Services provided by School: _____

I.E.P. in place: Yes No Copy available for review: Yes No

Activities child enjoys: _____

Items, Foods or Activities that are reinforcing for child: _____

Activities used for quiet time or for calming child:

Special Skills/Interests: _____

Behaviours to be aware of: _____
(i.e. does child run away, aggress, eat non edible items, etc.)

Prior experience(s) in group activities: _____

Communication/Organization:

How do caregivers communicate plans/schedule for daily activities?:

Verbal Sign Visual Schedule PECs (circle one or more)

How does your child handle transitions – what routines do you use to assist at these points?

Visual Stories: Other: _____

Medical Information:

Diagnosis of Special Needs: _____

Does your child have life threatening allergies? Yes No If yes, allergic to: _____

EPI pen available: _____ Typical Symptoms: _____

Does child currently take medication(s)?: Yes No If yes, list medication(s): _____

Do you anticipate your child will require medication(s) during attendance at camp? Yes No

Please provide details of timing and dosage: _____

Any other medical concerns: _____

Other professionals involved with your child:

Speech and Language _____ Occupational Therapist: _____

Psychologist/Psychiatrist: _____ Physiotherapist: _____

Behaviour Therapist: _____ Other: _____

Are copies of reports or programs available for review? Yes No

Diet:

Does your child have any food allergies? : _____

Foods your child prefers:

Food your child does not prefer:

Does your child prepare any of his own snacks or meals?: _____

Does your child require any special dietary considerations?:

If I were to choose one thing that I would like to see my child achieve through their experience with AFN it would be: _____

I, the undersigned, hereby grant permission for my child to participate in all activities, **and** for any supervised activity, walking trips or travel by car or bus to places outside the program's base location (Rotary Youth Centre). I agree that in the event that I cannot be reached at the time of illness or accident, or if the emergency is such that time does not permit such contact the directors or program leaders of Asperger's Friends Network, are authorized to secure proper treatment for, or provide any treatment prescribed by the physician caring for my child as well as arrange transportation to the Emergency Department of the nearest hospital, with no liability on the part of drivers or of the Autism Society Ontario – Halton Chapter and their staff/volunteers. I hold Autism Society Ontario – Halton Chapter, their agents/volunteers and employees harmless from any and all claims, damages, or other liabilities for injuries to my child.

Signature of Parent/Guardian: _____

Date: _____