

Date of Application _____

Child's Full Name _____ Grade _____

Gender _____ Birth Date _____ Age _____

Parents/Guardian Name(s) _____

Parent/Guardian email address (please print clearly) _____

Cell Phone Number(s) _____

Home Telephone Number (____) _____ Work Telephone Number (____) _____

Street Address _____

City, State _____ Zip Code _____

Emergency Contact (after parent/guardian contact listed above)

Name _____ ph. # (____) _____

MEDICAL INFORMATION

Does your child have a clinical diagnosis? Yes No

If yes, what is your child's current diagnosis? _____

Does your child currently display significant acting out, ritualistic, or self-stimulating behavior? Yes No

If yes, please describe _____

Will your child be attending with a TSS? Yes No

Does your child have any allergies or other medical concerns? Yes No

If yes, please list: _____

Is your child currently on medications? Yes No

If yes, please list medication: _____

If child will be taking medication during ESY program, please provide doctor note as to time and dosage administered.

Has your child had any of the following;

- | | | | |
|---------------------------|--|-------------------------|---|
| Autism Spectrum Disorder | <input type="radio"/> Yes <input type="radio"/> No | Injury to Self | <input type="radio"/> Yes <input type="radio"/> No |
| Aggression towards peers | <input type="radio"/> Yes <input type="radio"/> No | Injury to Others | <input type="radio"/> Yes <input type="radio"/> No |
| Aggression towards adults | <input type="radio"/> Yes <input type="radio"/> No | Running Away or Bolting | <input type="radio"/> Yes <input type="radio"/> No |
| Behavior Problems/Home | <input type="radio"/> Yes <input type="radio"/> No | Learning Disabilities | <input type="radio"/> Yes <input type="radio"/> No |
| Behavior Problems/School | <input type="radio"/> Yes <input type="radio"/> No | Intellectual Disability | <input type="radio"/> Yes <input type="radio"/> No |
| Destruction of property | <input type="radio"/> Yes <input type="radio"/> No | Noncompliance | <input type="radio"/> Yes <input type="radio"/> No |
| Emotional Disturbances | <input type="radio"/> Yes <input type="radio"/> No | Repetitive Acts | <input type="radio"/> Yes <input type="radio"/> No |
| Hyperactivity | <input type="radio"/> Yes <input type="radio"/> No | Hearing Impairment | <input type="radio"/> Yes <input type="radio"/> No Vision |
| Impairment | <input type="radio"/> Yes <input type="radio"/> No | Toileting Concerns | <input type="radio"/> Yes <input type="radio"/> No |

Describe in detail behaviors demonstrated by your child _____

Does your child have seizures? Yes No

If yes, describe _____

Does your child use verbal language to communicate? Yes No

If no, how does your child communicate needs? _____

Are there any other medical concerns that would limit your child's participation in the camp? Yes No

If yes, please describe _____

Are there any activities in which your child is not permitted to participate? Yes No

If yes, please specify _____

If your child has special dietary needs and cannot eat the lunch that is provided, you can send in a lunch and refrigeration will be provided.

CHILD'S PROFILE

How does your child get along with other children? _____

How does your child get along with adults? _____

What specific behavior problems should the ESY staff be aware of? _____

What can you suggest that might distract or redirect your child from inappropriate behavior? _____

Please describe any concerns that you may have relevant to your child's ESY program _____

Please list any individualized goals that you may have for your child's ESY program _____

Please add any other specific information that you feel will help the staff to better provide a beneficial experience for your child in ESY program _____

Please be sure to complete all information. All information is confidential and will be used by this agency to better serve your child.