10313 Aboite Center Road
Fort Wayne, IN 46804

Phone: (260) 459-6040
Fax: (260) 459-6010

SUMMER BRIDGE ENROLLMENT APPLICATION

All answers provided will be confidential to staff of the Children's Autism Center, Inc., unless authorized by parents/legal guardians of child.

Date of Application: _____

Program(s) Desired
Summer Bridge: **□Preschool (ages 3-5 years) Tuesday/Thursday 9-11 am $35/week** **□Elementary 1 (ages 6-8 years) Monday/Wednesday/Friday 9 am – 12 pm $50/week** **□Elementary 2 (ages 9-11 years) Monday/Wednesday/Friday 1-4 pm $50/week** **□Middle School (12-14 years) Tuesday/Thursday 1-4 pm $40/week** **□High School (15-18 years) Tuesday/Thursday 1-4 pm $40/week * this group meets at the north site**
Speech: **□ Assessment/Services**

Child/Client Information	
Last Name:	**Date of Birth:**
First Name:	**Gender:**
Middle Initial:	**Name preferred/Nickname:**
Home Phone:	**Grade in School:**
Address:	**School Attended:**
City:	
State: **Zip:**	

Mother or Legal Guardian Information	
Full Name:	**Relationship to Child, if guardian:**
Address:	
City:	**Occupation:**
State: **Zip:**	**Employer:**
Home Phone:	**Work Phone:**
Cell Phone:	
Email:	
Fax:	
Pager:	

Father or Legal Guardian Information	
Full Name:	**Relationship to Child, if guardian:**
Address:	
City:	**Occupation:**
State: **Zip:**	**Employer:**
Home Phone:	**Work Phone:**
Cell Phone:	
Email:	
Fax:	
Pager:	

Parents' Marital Status: □Married □Separated □Divorced □Single □Widowed
Child/client lives with: □Both parents □Mother □Father □Other_____

Child/Client's Siblings		
Name	**Age**	**Gender**
Current Pediatrician or General Practitioner	**Physician Phone Number**	
Physician Address:		
Diagnosing Dr.:	**Primary Diagnosis:** **Date of Diagnosis:**	
Address:	**Phone #:**	
Other condition:	**Date of Diagnosis:**	
Other condition:	**Date of Diagnosis:**	

Medication Information			
Is your child on medication? □ Yes □ No			
If yes, list medication information below:			
Medication	**Dosage**	**Time Administered**	**Purpose**

Will any of the above medication need to be administered during attendance at Children's Autism Center?
□ **Yes** □ **No**

Most Recent/Current School/Preschool	
School Name:	**Years attended:**
Address:	**Placement (typical classroom/modification, etc.):**
Phone:	
Are there any medical conditions that need to be considered when child/client is in group or speech therapy: □ **Yes** □ **No** If yes, please explain.	

What are your immediate goals for your child?

What would you like us to know about your child? Include likes and dislikes, please.

What, if any, behavior issues does your child have? Ex: self-injurious, aggression, lack of attention, etc., please explain.

_____
_____
_____
_____
_____
_____

Is there anything your child is fearful of? Include anything in any environment.

_____
_____
_____
_____

What current communication skills does your child have? Ex: sign language, PECS, verbal. Please explain.

_____
_____

Professional Crisis Management or PCM
PCM restraint procedures may be used with your child in the event of extreme behaviors that may endanger your child, other clients, staff, and/or property. Any CAC staff who will be utilizing PCM techniques is PCM trained and certified. If you have any questions or would like to see a demonstration of PCM techniques, we are happy to assist. A PCM authorization must be received by our office prior to your child's attendance at our center.

For more information on PCM, see www.pcma.com.

The undersigned hereby acknowledge that the information contained in this application is accurate in all respects.

Parent/Guardian (print name)_____

Signature of Parent/Guardian):_____

Date:_____

q PCM Authorization Signed

Please mail all the above to:
Children's Autism Center, Inc.
10313 Aboite Center Rd
Fort Wayne, IN 46804

Office use only
Date received _____ Initials _____ Incomplete? Y / N Follow up sent _____