

Application

Dr. Gertrude A. Barber National Institute
100 Barber Place, Erie, Pennsylvania 16507

CONNECTIONS Summer Therapeutic Activity Program

Enrollment is limited. Please apply early!

Child Name: _____ Date of Birth: ____/____/____

Parent/Guardian _____ Home Phone: (____) _____

Address: _____ Work Phone: (____) _____

City, State, Zip _____ Cell Phone: (____) _____

School District: _____ School Name: _____

Does your child have an IEP? Yes No

If yes, what is your child's current educational placement – check all that apply:

- Regular Education
- Emotional Support
- Autistic Support
- Learning Support
- Other _____

Please provide detailed information for the following questions. Thank you.

School Performance: _____

Current Diagnosis (please list all): _____

Why would you like your child to attend CONNECTIONS? _____

How does your child feel about attending CONNECTIONS? _____

What are your primary concerns about your child? _____

What are your child's primary concerns? _____

What do you like best about your child? _____

What are your child's strengths? _____

Does your child have any history of behavioral concerns such as aggression or running away that might compromise his/her safety or the safety of others?

Does your child have any other behavior of concern? _____

What will your child do when he/she is upset/angry? _____

What helps to calm your child when he/she is upset? _____

How does your child relate to his/her peers at school? _____

How does your child relate to his/her peers in the neighborhood? _____

Does your child have any medical or dietary concerns? _____

Does your child have any sensitivities to light, sound, textures etc.? _____

Please list any medication your child is currently taking. Include dosage amount and times.

Please describe your child's understanding of his/her diagnosis of Autism or Asperger Syndrome.

Is there any other information we should know? _____

Does your child currently receive wrap-around services?

- No
- Yes - please provide the following information:

Wrap-around Provider: _____

Wrap-around Contact Person: _____ Phone (____) _____

Date of next reauthorization meeting: _____

I authorize the release of information between my Wrap-around Provider and the Dr. Gertrude A. Barber National Institute for the purposes of incorporating the CONNECTIONS Summer Program in my child's treatment plan.

I **do not** authorize the release of information between my Wrap-around Provider and the Dr. Gertrude A. Barber National Institute

Parent Signature

Date