Autism Summer Programming
2021 Application

This application is intended for the registration, and qualification of scholarship, to the Hope Enterprises ACCE Summer Program. The Autism Collaborative Centers of Excellence (ACCE) began in 2019 with the intention of identifying service gaps for individuals with an Autism Spectrum Diagnosis in Lycoming and Clinton County. This pilot summer program objective is to highlight community engagement and participation with a focus on social and life skills.

STUDENT'S INFORMATION:

Student's Full Name: _____

Nickname: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Gender (please select one): □ Male □ Female

High School: _____

PRIMARY CONTACT INFORMATION:

Name: _____

Relationship to Student: _____

Is your address the same as the student's? □ Yes □ No (Please indicate below)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (home): _____ Phone (work): _____

Phone (cell): _____ Email: _____

Preferred method of contact:

□ Home Phone □ Cell Phone
□ Work Phone □ Email

SECONDARY CONTACT INFORMATION:

Name: _____

Relationship to Student: _____

Is your address the same as the student's? □ Yes □ No (Please indicate below)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (home): _____ Phone (work): _____

Phone (cell): _____ Email: _____

Preferred method of contact:

□ Home Phone □ Cell Phone
□ Work Phone □ Email

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship to Student: _____

Is your address the same as the student's? □ Yes □ No (Please indicate below)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (home): _____ Phone (work): _____

Phone (cell): _____ Email: _____

Preferred method of contact:

□ Home Phone □ Cell Phone
□ Work Phone □ Email

OTHER:

Who has permission to pick up your child?

Name	Relationship	Phone

Does your child have a state caseworker? □ Yes (If so, please provide below) □ No

Caseworker's Name: _____

State Agency: _____

Phone Number: _____ Extension: _____

MEDICAL INFORMATION:

Primary Care Physician: _____

Physician's Name: _____

Phone Number: _____ Fax Number: _____

Does the camper have health insurance? □ Yes □ No

Health Insurance Provider: _____

Group Number: _____ Member ID Number: _____

Name of Insured: _____

Will your child need to take any medications while at summer programming?

□ Yes (see below) □ No

If so, please list here:

Medication Rx #: _____

Dosage Time: _____

Route: _____

Physician: _____

Provider Phone: _____

Please initial here: _____ My child has permission to receive the listed medication while under our care.

Please list any side effects of which we should be aware:

_____

_____

_____

My child has permission to receive (please check here):

□ Tylenol □ Advil □ Motrin □ Benadryl

Dosage: _____

Please initial here: _____

In the last 12 months, has your child experienced any of the following? (check all that apply)

□ Frequent ear infections
□ Diagnosis of heart defect or disease
□ Bleeding/clotting disorder
□ Urinary tract infection
□ Respiratory problems
□ Asthma
□ Seizures
□ Chicken pox
□ Measles
□ Diabetes
□ Hay fever
□ Pneumonia

If yes, please provide details:

_____
_____
_____

Does your child have any allergies? □ Yes □ No

If yes, please specify:

_____
_____
_____

Does your child have any dietary restrictions (other than allergies)? □ Yes □ No

If yes, please specify:

_____
_____
_____

Does your child have any vision, hearing, mobility, healthcare, or behavioral needs of which we should be aware? □ Yes □ No

If yes, please specify:

_____
_____
_____
_____
_____
_____

IMMUNIZATIONS:

Month/Year	**Immunization**
_____/_____	DTP (Diphtheria, Tetanus, Pertussis)
_____/_____	OPV (Oral Polio Vaccine) & IPV (Inactivated Polio Vaccine)
_____/_____	HIB (Haemophilus Influenzae)
_____/_____	MMR (Measles, Mumps, Rubella)

COMMUNICATION:

How does your child prefer to communicate?

□ Speaks clearly
□ Speaks but may be difficult to understand
□ Gestures
□ Uses sign language
□ Uses communication board
□ Other: _____

Language(s) spoken/understood: _____

Notes: _____
_____
_____

STUDENT'S DAILY LIFE:

With whom does your child live? Please list all members of the household.

_____
_____
_____

What are your child's favorite activities to do at home?

_____
_____
_____

Please list any of your child's dislikes or fears of which we should be aware.

_____
_____
_____

Has your child previously attended a summer program? □ Yes □ No

If yes, was it a positive experience? □ Yes □ No

Explain: _____
_____
_____

Does your child follow directions? □ Yes □ No

Explain: _____
_____
_____

Does your child require assistance with daily tasks such as eating, going to the bathroom, dressing, showering, or moving from place to place? □ Yes □ No

If yes, will a caregiver be assisting your child at summer programming to assist with these tasks?

□ Yes □ No

If no, please describe the assistance needed. Our summer program will do our best to find the assistance your child needs.

_____
_____
_____
_____

Does your child use any assistive devices? (e.g., wheelchair, braces, catheter, communication board)

□ Yes □ No

Please describe the proper maintenance and handling of the device(s):

_____
_____
_____

If your child is bringing a power wheelchair, please be sure to bring the charger to camp

ACTIVITIES:

Does your child have any restrictions to activities that we should be aware of? If so, please explain.

_____
_____
_____

BEHAVIOR:

Are there certain behaviors that your child is working on at school/home that should be encouraged at camp? If so, please explain.

_____
_____
_____

What motivators (e.g., games, activities, foods) are reinforcers for your child?

_____
_____
_____

Please list any triggers that may agitate your child. (e.g., loud noises, odd textures, etc.)

_____
_____
_____

Does your child have any behaviors of which the program staff should be aware?

_____
_____
_____

What is the best way to assist your child if he/she gets overwhelmed and/or upset?

_____
_____
_____

Does your child have a Behavior Intervention Plan (BIP) or Individualized Education Program (IEP) at school? □ Yes □ No

If yes, please include a copy with this application.

Additional comments:

_____
_____
_____
_____
_____
_____

Hope's Autism Summer Programming is committed to open and honest communication with parents and to ensure the best experience for all of our students. We encourage you to visit our facility and call us at 570-326-3745 with any additional questions, concerns, or information about your child.

Parent/Guardian Printed Name: _____ Date: _____

*Parent/Guardian Signature: **X** _____*

Autism Collaborative
Centers of Excellence
REGIONAL HUB:
HOPE ENTERPRISES