THE AUTISM PROJECT
410-286-8240
PO Box 1518
North Beach, Md. 20714

The Autism Project Participant Application Form

PARTICIPANT INFORMATION

Participant's Name_____

Age_____ Birthdate____/____/_____ Gender _____ Grade _____

Primary Disability/Diagnosis _____

Medical Conditions (Seizures, Asthma, Etc)_____

Further Information (Warning Signs/Duration) _____

Are there any Dietary Restrictions/Allergies? Yes _____ No _____

Further Information _____

Please list current medications and possible side effects _____

Does child require medication during program hours? Yes _____ No _____

***If yes, a medication form is required to be completed in entirety.

FAMILY INFORMATION

Primary Guardian's Name_____ Primary Address_____

Home Phone #_____ City_____Zip_____

Primary Cell #_____ Primary Work #_____

Secondary Guardian's Name_____ Secondary Cell # _____

Primary Email_____ Secondary Email _____

PRIMARY Contact Name and **Number** for this participant during program hours

_____

EMERGENCY CONTACTS

Name_____ Relationship_____Phone #_____

Name_____ Relationship_____Phone #_____

Please give the names of any individuals authorized to pick up the participant **other** then yourself and please be aware that our staff is required to ask to see ID for verification.

1. _____
2. _____

CURRENT SERVICES INFORMATION

School Name _____
School Address _____ City _____
Teacher's Name _____ Phone # _____

Current Therapy/Service Providers Names and Contact Information
Doctor _____ Phone # _____
OT _____ Phone # _____
PT _____ Phone # _____
SLP _____ Phone # _____
Other Providers _____

Communication

Participants Primary Means of Communication	Please mark appropriate response	**Comments**
Speech is Clear/Talks in Complete Sentences		
Speech is Difficult to Understand		
Uses Short or One Word Phrases		
Nonverbal		
Uses Sign Language/Gestures		
Uses PECS		
Uses AAC Device		
Other		

Best Method of Assistance

Please Check All that Apply							
	Follows Directions		Verbal Prompts		Peer Buddy		Modeling/Demonstrations
	Visuals/Pictures		Gesture Prompts		Physical Prompts		Hand Over Hand
	Equipment/Adaptations		Other				
Comments:							

Activities of Daily Living

Please mark appropriate response	**Independent**	**Requires Some Assistance**	**Requires Full Assistance**	**Comments**
Eating				
Awareness of Dietary Restrictions				
Dressing/Undressing				
Toileting				
Reading				
Writing				
Other				

Safety

Please mark appropriate response	Independent	Requires Some Assistance	Requires Full Assistance	Comments
Stay with Group				
Communicates Name and Phone #				
Responsible for Own Belongings				
Recognizes Danger				
Manages Money				
Swimming Ability				
Toleration of Band-Aids or Wristbands				
Other				

Behaviors

Does Participant Exhibit Behaviors Below?	Please mark appropriate response	**Comments**
Withdrawn/Shy/ Easily Discouraged		
Hyperactive		
Short Attention Span/Easily Distracted		
Runs Away/Elopes		
Aggressive-Bites/Scratches/Hits/Kicks		
Harms Self		
Displays Strong Fears (Explain)		
Please name some Motivators for your Camper?		
Is there a behavior plan in place? Yes___ NO____ If so please attach a copy		

Please give a brief description of behavior management and methods used at home/school so our staff may be consistent in behavior management techniques for your child:_____

_____

_____

Please Describe Sleep Patterns _____

_____

Please Describe Eating Patterns _____

_____

Recreation

Participant enjoys the following: Please Check All that Apply							
	Swimming		Games		Community Outings		Sports
	Video Games		Arts and Crafts		Music		Other
Comments:							

Socialization

Please Check All that Apply					
	Interacts with Peers		Does not Interact with Adults		Prefers to be Alone
	Does not Interact with Peers		Enjoys being with a Group		Tolerant of Loud Noises
	Interacts well with Adults		Prefers Small Groups		Does Not Tolerate Loud Noises
Comments:					

Please list any special talents or interests _____

_____

What is your main goal for your child attending TAP?

_____

_____

Medicaid Information

Medicaid Number _____ Effective Date _____

Service Coordinator _____ County _____

Signature _____ **Date** _____

All Provided Information is Confidential and will Only be shared with TAP Staff