For Office Use Only

__ Registration Packet
__ Birth Certificate & Social Security Number
__ Immunization Certificate
__ Medical Release- FORM E-1
__ Medication Release- FORM E-2
__ Medical Plans:
  __ FORM F-1- Asthma
  __ FORM F-2- Diabetes
  __ FORM F-3 – Seizure
  __ FORM F-4- Food Allergy
__ Emergency Information - FORM G
__ Tuition Agreement - FORM H
__ Automatic Account Withdrawal - FORM I
__ Voided Check (if ACH- attach to FORM I)
__ Extended Day AM/PM - FORM J
__ Lunch, Snack, & Food Form - FORM L
__ Media Release - FORM N
__ FBA (Functional Behavioral Assessment) Form
__ SCM (Safe Crisis Management) Form
__ Educational History/About Your Child/Goals Forms
__ Parent Volunteer Form

REGISTRATION PACKET
2018-2019

BLUEGRASS CENTER FOR AUTISM
Teach to Learn. Learn to Live.

Name of Child: _____
(First) (Middle) (Last)

Child's Date of Birth: _____ Child's Age: _____ Child's Sex: M F

Child's Address: _____
(Street) (City) (State) (Zip Code)

Parent's Cell (main) Phone: _____

Child's Social Security #: _____

Bluegrass Center for Autism admits children of any race, color, national and ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to children at the center. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its policies, admissions policies and other center-administered programs.

Parent/Guardian Information

(adult(s) with whom the child lives)

Parent/Guardian Name: _____

Relationship to child: _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer of Parent/Guardian: _____

Additional Parent/Guardian Name: _____

Relationship to child: _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer of Parent/Guardian: _____

PLEASE NOTE: In order for your child's experience at Bluegrass Center for Autism to be successful, we require each adult family member to attend team conferences, and parent workshops to ensure effective reinforcement may occur at home.

Family Information

Family Members/Siblings

Name: _____ Age: _____ Relationship to child: _____

Name: _____ Age: _____ Relationship to child: _____

Name: _____ Age: _____ Relationship to child: _____

Name: _____ Age: _____ Relationship to child: _____

Name: _____ Age: _____ Relationship to child: _____

Is the child you are enrolling into BCA adopted? Yes No If "Yes", at what age? _____

Please complete the information below for "Non-Custodial Adult(s)" (grandparents, step-parents, etc.) who have a caretaking role in the child's life.

Name: _____ Relationship to child: _____

Home Address: _____

(Street) (City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____

Name: _____ Relationship to child: _____

Home Address: _____

(Street) (City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____

Medical Information

Please complete medical information for all that apply

Child's Primary Care Physician

Name: _____ Phone Number: _____

Address: _____

(Street) (City) (State) (Zip Code)

Child's Specialty Care Physician

Name: _____ Phone Number: _____

Specialty: _____

Address: _____

(Street) (City) (State) (Zip Code)

Child's Psychologist/Psychiatrist

Name: _____ Phone Number: _____

Specialty: _____

Address: _____

(Street) (City) (State) (Zip Code)

Child's Dentist

Name: _____ Phone Number: _____

Address: _____

(Street) (City) (State) (Zip Code)

Child's Ophthalmologist

Name: _____ Phone Number: _____

Address: _____

(Street) (City) (State) (Zip Code)

Medical Information (continued)

Please check all that apply for your child enrolling in BCA

__ Allergies:
- __ Food: _____
- __ Insects: _____
- __ Drugs: _____
- __ Latex
- __ Seasonal: _____
- __ Other: _____

__ Anxiety Disorder
__ Asthma or Breathing Conditions
__ Asperger's Syndrome
__ Attention Deficit Disorder (ADD)
__ Attention Deficit Hyperactivity Disorder (ADHD)
__ Autism Spectrum Disorder (ASD)
__ Bladder Conditions
__ Bowel Conditions
__ Cerebral Palsy
__ Cystic Fibrosis
__ Dental Conditions
__ Diabetes
__ Down Syndrome
__ Head/Spinal Injuries
__ Deaf or Hearing Impaired
__ Heart Conditions
__ Muscle Conditions
__ Seizures
__ Speech Delays/Conditions
__ Visually Impaired/Blindness
__ Other: _____
__ Other: _____
__ Other: _____

Date of last eye exam: _____ Date of last hearing test: _____

Please describe any other important medical/health related information about your child:

_____

_____

_____

Please list all your child's medications, prescriptions, supplements (including over-the-counter medication) below. Use extra page for additional medications, prescriptions and supplements.

Medication	Dosage	Times per day	Condition	Physician

Please Note: Please make BCA staff aware of any adjustments/changes that are made to your child's medications.

Medical Information (continued)

In an emergency, do you give Bluegrass Center for Autism's staff permission to send your child (properly supervised) to an alternative hospital or physician, if you and/or your physician(s) cannot be reached? (circle one) Yes No

As a parent/guardian, I authorize treatment of _____ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature: _____ Date: _____

Documentation of your child's previous evaluations are needed. Specifically, but not limited to:

__ Educational Evaluations/Plans

__ Psychological Evaluations

__ Speech and Language Evaluations/Plans

__ Occupational Therapy Evaluations/Plans

Medical Information (continued)

Does your child have an Autism Spectrum Disorder (ASD) diagnosis? (circle one) Yes No

Who gave your child his/her ASD diagnosis?

Physician's Name: _____

Agency: _____

Date of ASD Diagnosis: _____ Child's Age when diagnosed with ASD:_____

What prompted you to seek an evaluation for your ASD diagnosis? _____

_____

_____

Please complete only if your child has received services in any of the following areas:

Speech and Language

Therapist's Name: _____

Agency: _____ When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Occupational Therapy

Therapist's Name: _____

Agency: _____ When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Physical Therapy

Therapist's Name: _____

Agency: _____ When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Applied Behavior Analysis (ABA) Therapy

Therapist's Name: _____

Agency: _____ When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Medical Information (continued)

Psychology or Psychiatric Services/Therapy

Therapist's Name: _____

Agency: _____ When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Does your child have a diagnosis of Epilepsy, or Seizure Disorder? (circle one) Yes No

If yes, please explain the frequency of seizures: _____

_____

Emergency Information

Child's Name: _____

Parent/Guardian names: _____

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

Additional Cell Phone: _____ Work Phone: _____

Email address: _____ Email address: _____

In the event of an emergency, and the parents/guardians listed above cannot be reached, list the name, phone number and email address of individuals Bluegrass Center should contact *(list should be adults over the age of 18):*

1. Name: _____ Relationship to child: _____

Phone: _____ Email address: _____

2. Name: _____ Relationship to child: _____

Phone: _____ Email address: _____

3. Name: _____ Relationship to child: _____

Phone: _____ Email address: _____

4. Name: _____ Relationship to child: _____

Phone: _____ Email address: _____

As a parent/guardian, I authorize treatment of _____ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only of reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature: _____ Date: _____

Form MIR

Bluegrass Center for Autism

Medical Information Release Form

I, (please print) _____, Parent/Guardian of _____, a child attending Bluegrass Center for Autism, authorize the transmission of information regarding my child between Bluegrass Center for Autism representatives and my child's physician(s). I understand that all information regarding my child's physical, developmental, and emotional health will be kept confidential.

The following is a list of physicians who may be contacted by Bluegrass Center for Autism representatives on behalf of my child:

Primary Care Physician (Pediatrician): _____ Phone: _____

Neurologist (if applicable): _____ Phone: _____

Psychiatrist (if applicable): _____ Phone: _____

Outside Therapists: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE THE HIPAA PRIVACY AUTHORIZATION FORM (next page) FOR EACH PROVIDER LISTED ABOVE

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1) **Authorization**
   I authorize _____ (healthcare provider) to use and disclose the protected health information described below to Bluegrass Center for Autism.
2) **Effective Period**
   This authorization for release of information covers the period of healthcare from:
   a) □ _____ to _____
   - - OR - -
   b) □ all past, present, and future periods.
3) **Extent of Authorization**
   a) □ I authorize the release of the complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for _____
   - - OR - - (client name and date of birth)
   b) □ I authorize the release of the complete health record for _____ (client name and date of birth) with the exception of the following information:
      □ Mental health records
      □ Communicable diseases (including HIV and AIDS)
      □ Alcohol/drug abuse and treatment
      □ Other (please specify): _____
4) This health information may be used by the entity I authorize to receive this information for medical/mental health treatment or consultation, billing or claims payment, or other purposes as I may direct.
5) This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7) I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8) I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of parent or guardian Date

_____ _____
Printed name of parent or guardian Relationship to client

Form MDR

Bluegrass Center for Autism

Medication Distribution Release Form

(Prescriptions Only)

I, (please print) _____, Parent/Guardian of _____, a child attending Bluegrass Center for Autism, authorize Bluegrass Center for Autism employees to administer the following medication(s) in the following dosage to my child. I release Bluegrass Center for Autism from all liability for administering the stated medication in the stated dosage.

- *All medication must be brought to Bluegrass Center for Autism in it's original container, with prescription label on the original container.*
- *This Release does NOT need to be completed for "over-the-counter" medicine and/or supplements, however Bluegrass Center for Autism must be aware of any "over-the-counter" medicine and/or supplements that are given to your child at home.*

Medication (please write the entire name): _____

Dosage: _____ Frequency (how many times per day): _____

Instruction for administering (include time of day, special instructions, etc.): _____

_____

Parent/Guardian Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Phone: _____ Physician's Agency/Group: _____

Please note: Please print this page off for each prescription medication your child is currently taking.

Form E-1

Allergy Emergency Plan

(only complete if applicable)

Child's Name: _____ Age: _____

Parent/Guardian Name: _____ Phone: _____

As a parent/guardian, I authorize treatment of _____ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature: _____ Date: _____

Type of Allergy: _____

Identify the triggers which begin allergic reaction: _____

_____

Symptoms of allergic reaction: _____

_____

Instructions if allergic reaction occurs: _____

_____

Type of Allergy: _____

Identify the triggers which begin allergic reaction: _____

_____

Symptoms of allergic reaction: _____

_____

Instructions if allergic reaction occurs: _____

_____

Form E-2

Seizure Emergency Plan

(only complete if applicable)

Child's Name: _____ Age: _____

Parent/Guardian Name: _____ Phone: _____

As a parent/guardian, I authorize treatment of _____ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature: _____ Date: _____

Type of seizure: _____

Identify the triggers which begin seizures: _____

_____

Symptoms of seizures: _____

_____

Instructions if seizure occurs: _____

_____

Type of seizure: _____

Identify the triggers which begin seizures: _____

_____

Symptoms of seizures: _____

_____

Instructions if seizure occurs: _____

_____

Form E-3

Asthma Emergency Plan

(only complete if applicable)

Child's Name: _____ Age: _____

Parent/Guardian Name: _____ Phone: _____

As a parent/guardian, I authorize treatment of _____ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature: _____ Date: _____

Identify the triggers for an asthma attack: _____

_____

Symptoms of an asthma attack: _____

_____

Instructions if an asthma attack occurs: _____

_____

Identify the triggers for an asthma attack: _____

_____

Symptoms of an asthma attack: _____

_____

Instructions if an asthma attack occurs: _____

_____

Form E-4

Diabetic Emergency Plan

(only complete if applicable)

Child's Name: _____ Age: _____

Parent/Guardian Name: _____ Phone: _____

As a parent/guardian, I authorize treatment of _____ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature: _____ Date: _____

Identify the triggers for a diabetic emergency: _____

_____

Symptoms of a diabetic emergency: _____

_____

Instructions if a diabetic emergency attack occurs: _____

_____

Identify the triggers for a diabetic emergency: _____

_____

Symptoms of a diabetic emergency: _____

_____

Instructions if a diabetic emergency attack occurs: _____

_____

Bluegrass Center for Autism

Payment Policy

Financial obligations are crucial to the successful operation of Bluegrass Center for Autism. Bluegrass Center for Autism's administration and Board of Directors set and approve our Payment Policy and fees annually. All parents/guardians must sign this agreement in order for their child to attend Bluegrass Center for Autism and agree to make payments as selected below.

Regular Session Deposit: A $1,000.00 *non-refundable* deposit must be made during the registration process/or during the annual "re-registration" process for each child who plans on attending Bluegrass Center for Autism. Deposits will be applied towards the child's annual fees.

Payment Option: Please select a Regular Session (August – May) payment option:

1. ___ Automatic ACH withdrawal from your checking/savings account. (suggested method) If you select this option, please complete the provided ACH form.

2. ___ Personal Check/Money Order. (Cash is not accepted)

3. ___ Insurance Billing Option. *MUST HAVE PRE-APPROVAL FROM BCA BILLING DEPARTMENT TO SELECT THIS OPTION*

Payment Frequency: Please select a Regular Session (August – May) payment frequency option:

1. ___ Full payment due prior to the beginning of Regular Session.

2. ___ Quarterly payments due in August, November, February and May.

3. ___ Bi-Annual payments due in August and January of Regular Session.

4. ___ Monthly payments due on the 20th of each month.

5. ___ Bi-Monthly payments due on the 5th and 20th of each month.

Bluegrass Center for Autism

Payment Policy (continued)

Payment Policies:

1. Failure to submit payments as agreed above will result in your child's dismissal from Bluegrass Center for Autism, and all collection options will be sought if necessary.

2. A $50.00 charge will be applied to any account whose ACH payment and/or check does not clear or is declined.

3. Bluegrass Center for Autism does NOT accept cash as a form of payment.

4. Bluegrass Center for Autism payments for services are non-refundable.

5. Deposits for Regular Session and Summer Session are non-refundable.

6. Families who utilize "Insurance Billing" are responsible for all costs not covered and/or paid by their insurance company.

I have read, understand and agree to the conditions outlined above. I understand and acknowledge that by signing below, I agree to submit payments as outlined above for all payments due to Bluegrass Center for Autism.

Name of Child

Parent Signature Date

Parent Signature (if applicable) Date

Bluegrass Center for Autism

ACH Form

(only complete if applicable)

Payer's Contact Information

Child's Name: _____

Payer's Name: _____

Secondary Contact: _____

Payer's Address: _____
Street *City* *State* *Zip*

Payer's Phone: _____

Payer's Email Address: _____

ACH Banking Information

Select one: ___: Checking Account ___: Savings Account

Please attach a "VOIDED" check to this form –or- complete the information below:

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

I hereby authorize Bluegrass Center for Autism to initiate debit entries to my account indicated above (or attached) and my bank, to debt the same such amount. This authority is to retain in full force and effect until Bluegrass Center for Autism and my bank have received written notification from me of its termination. I hereby agree to any and all information and agreements noted above.

Payer's Signature: _____ ***Date:*** _____

Before and Aftercare Program Form

Name of Child: _____

Bluegrass Center for Autism offers a Before Program daily from 7:30am – 8:45am at each campus. Bluegrass Center for Autism offers an After Care Program on *MOST* Friday's from 1:30pm – 3:30pm. ***PLEASE SEE THE BCA CALENDAR FOR DATES AFTER CARE IS NOT OFFERED***

Rates for Bluegrass Center of Autism Before and After Care Program:

Before Care:

- 7:30am -7:59am: **$20.00**
- 8:00am – 8:44am: **$15.00**

After Care:

- 1:30pm – 3:30pm: **$30.00**

Please select options below. You may adjust this throughout the year as needed, provided you speak with your Program Director first.

1. ___ Yes, I plan on my child attending the **Before Care Program** at Bluegrass Center for Autism on the days circled here:

Mondays **Tuesdays** **Wednesdays** **Thursdays** **Fridays**

2. ___ Yes, I plan on my child attending the **After Care Program** at Bluegrass Center for Autism on the Friday's it is offered.

3. ___ No, I do NOT plan on my child attending the Before and After Care Program at Bluegrass Center for Autism.

Parent Signature: _____ Date:_____

Lunch, Snacks and Food Form

(EAST CAMPUS PARENTS/GUARDIANS ONLY)

Child's Name: _____

Due to the dietary needs of each child at Bluegrass Center for Autism, we are requiring all lunches, snacks and food reinforcers to be brought from home.

Bluegrass Center for Autism will be able to store all lunches/food on a daily basis.

Please Note: If your child has any food allergies, please make note of these allergies on the E-1 (Allergy Emergency) form.

Parent Signature: _____ Date:_____

Bluegrass Center for Autism

Media Release Form

Child's Name: _____

I, the parent/legal guardian grant my permission for Bluegrass Center for Autism to exhibit photographs, audio, video and/or likeness of the above-named child in print and/or electronically for Bluegrass Center for Autism purposes only.

I agree that Bluegrass Center for Autism may use such photographs, audio, or video of my child for any lawful purpose, including BCA sanctioned purposes such as publications, newspaper articles, professional development, marketing materials, BCA website, BCA social media, hallway bulletin boards, classroom decorations or other such material.

I have read and understand the above, and give my consent as marked below:

___ I/We hereby give permission to Bluegrass Center for Autism to use my child's image for the purposes stated above.

___ I/We hereby give permission to Bluegrass Center for Autism to use my child's image only within the confines of Bluegrass Center for Autism (hallways, classrooms, etc.).

___ I/We hereby do NOT give permission to Bluegrass Center for Autism to use my child's image in any form or capacity.

Printed name of parent/guardian: _____

Signature of parent/guardian: _____

Date: _____

Bluegrass Center for Autism

Functional Behavior Assessment Consent Form

I, _____, parent/guardian of _____, give my informed consent to the Bluegrass Center for Autism to conduct a Functional Behavior Assessment (FBA) for my child. The purpose of this assessment is to identify a hypothesized function or functions for behavior(s) that may be targeted for reduction. Knowledge of the function(s) of behavior is essential for successful reduction of the behavior and must be known prior to developing a Behavior Plan. This assessment may include the following:

- Indirect assessment
    - Informal and/or structured interviews of parents and/or staff
    - Informal and/or structured interviews of other therapists
- Direct observation
    - Collection of data on the antecedents and consequences to behaviors

As a parent/guardian, you may request the results of this assessment at any point. In addition, results will be discussed with you when your assigned Behavior Analyst reviews your child's Behavior Plan with you.

_____ _____

Parent/Guardian Date

Bluegrass Center for Autism

Safe Crisis Management Release

I _____ parent/guardian to _____, a learner and or prospective learner at Bluegrass Center for Autism, give permission for the trained staff at Bluegrass Center for Autism to implement Safe Crisis Management (SCM) procedures with my child, only if necessary. I understand that these procedures will only be used as a last resort and after all other procedures have been implemented but deemed unsuccessful by our Program Director or Program Coordinator. I understand that there is a risk for possible injury to my child but that all precautions will be taken to prevent injury. I realize that these procedures are utilized to keep my child, other children and the staff at Bluegrass Center for Autism safe at all times. A Program Director will notify me that day and provide me with written documents detailing the event, if any SCM restraints are used.

I am aware that staff at Bluegrass Center for Autism have been trained and certified by a certified SCM trainer through JKM Training, Inc.

Parent Signature Date

Goals

Please list long term and short term goals you would like your child to achieve while attending Bluegrass Center for Autism:

Short Term Goals:

1. _____

_____. Time Frame: _____

2. _____

_____. Time Frame: _____

3. _____

_____. Time Frame: _____

Long Term Goals:

1. _____

_____. Time Frame: _____

2. _____

_____. Time Frame: _____

3. _____

_____. Time Frame: _____

Educational History

Name of current school or placement: _____

How long has your child been enrolled in this current school/placement: _____

Reason for seeking placement in Bluegrass Center for Autism: _____

_____

Please list all schools/placements your child has attended:

1. _____ Time Frame: _____
2. _____ Time Frame: _____
3. _____ Time Frame: _____
4. _____ Time Frame: _____
5. _____ Time Frame: _____

What are your child's strengths: _____

_____

_____

In what area's can your child improve: _____

_____

_____

Does your child have a home program? If yes, please describe the type of program, the frequency of sessions, length of sessions and individuals involved in the sessions: _____

_____

_____

_____

About your Child

What items/activities are most motivating to your child?

Visual Motivators *(i.e. TV, movies, computer games, cell phones, lights, etc.)* _____

_____

_____

Audio Motivators: *(i.e. music, books with sound, whistles, instruments, singing, etc..)* _____

_____

_____

Touch/Tactile Motivators: *(i.e. squishy/stress balls, sand, lotion, etc.)* _____

_____

_____

Kinetic/Movement Motivators: *(i.e. running, trampolines, rocking, jumping, etc.)* _____

_____

_____

Please list any items/activities your child dislikes: *(i.e. loud noises, swinging, certain toys, etc.)* _____

_____

_____

About your Child (continued)

Please list and describe behaviors your child currently demonstrates that you would like to see continued or increased: _____

_____

_____

Please list and describe behaviors your child currently demonstrates that you would like to see decreased or stopped: _____

_____

_____

How does your child communicate? _____

_____

_____

Does your child accept "no" when s/he cannot have a desired item/activity? If not, please describe your child's reaction: _____

_____

_____

Are you successfully able to remove reinforcing items/activities at home and/or in public? Please describe: _____

_____

_____

About your Child (continued)

Does your child have any diet restrictions? ___ Yes ___ No

If so, please list: _____

_____

_____

Does your child eat a variety of foods: ___ Yes ___ No

If "No", what types of food does your child eat? _____

_____

_____

Does your child have difficulty sleeping through the night? ___ Yes ___ No

If so, please describe: _____

_____

_____

Is there anything else we should know about your child? _____

_____

_____

_____

Parent/Guardian Volunteering

Throughout the year, Bluegrass Center for Autism hosts and participates in multiple fundraisers and community functions to help support our mission. Having parent/guardian volunteers help keep the cost down for Bluegrass Center for Autism to staff these events. Bluegrass Center for Autism requires a parent/guardian or family member (over the age of 18) to volunteer for at least one BCA fundraiser or event each year. Please mark next to the event(s) that you or a family member would be interested in volunteering for on behalf of Bluegrass Center for Autism. You are not guaranteed you will be volunteering for the selection you make below, so please select more than one.

___ "Highlands Beer Fest" ValuMarket Fundraiser for BCA (usually held in May)

___ "Outrunning Autism" FEAT 5K Run/Walk (usually held in June)

___ "Boots, Barrels and Bluegrass" BCA Fundraiser Event (usually held in September)

___ Major BCA Fundraiser: "Puzzablilities" (usually held in November)

___ "Business Expos" Attend Health Fair/Business Expo to hand out BCA info (dates vary)

___ Other smaller fundraisers/events throughout the year (dates vary)