One for Autism
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San Antonio, Texas 78212
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For Office Use Only:
Date Received: _____
Date of Admission: _____

ENROLLMENT APPLICATION

Application for: ___Day Treatment Program ___After-School Program

___AUsome Social Skills Group ___Summer Camp

Application completed by: _____ Date: _____

Relationship to student: _____

STUDENT INFORMATION

Name:		DOB:	Age:
Gender: ____Male ____Female		Home Phone:	
Street Address:	City:	State:	Zip:
Diagnosis:	Age at Diagnosis:	Current Developmental Age Equivalent:	
Is student verbal? __Yes __No Please describe:			
Maladaptive Behaviors (type, frequency, and severity):			
Current functioning:			
Interests			

CURRENT SCHOOL PLACEMENT

Name of School:		Current Class/Grade:	
Name of Teacher:		School Phone Number:	
Street Address:	City:	State:	Zip:

PARENT/GUARDIAN INFORMATION

Mother's Name:			Father's Name:		
Occupation/Employer:			Occupation/Employer:		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Home Phone:			Home Phone:		
Work Phone:			Work Phone:		
Cell Phone:			Cell Phone:		
E-mail Address:			E-mail Address:		

MEDICAL INFORMATION

Pediatrician Name:	Hospital Affiliation:	
Street Address:	Phone Number:	
City:	State:	Zip:
Does your child have any medical conditions other than autism? ___Yes ___No If yes, what are they?		
If your child's medical condition stable? ___Yes ___No If no, please describe:		
Does your child have allergies? ___Yes ___No If yes, what are they?		

Please list all medications your child is currently taking:

Name of Medication	**Dosage**	**Dosage Interval**	**Purpose**	**Time on medication**

Is your child on a special diet? ___Yes ___No If yes, please describe:
Has your child ever been hospitalized? ___Yes ___No If yes, please state reason and date of hospitalization:

TREATMENT HISTORY

Please provide the following information for each service provider your child has seen. Copy as many pages as necessary to give us a complete history of your child's treatment:

Provider Name:	Title/Specialty:		
Street Address:	City:	State:	Zip:
Type of Treatment:	Length of Treatment:		
	Is the student still receiving services? ___Yes ___No		
Did the student benefit from this treatment? ___Yes ___No If yes, how? If no, why not?			

Provider Name:	Title/Specialty:		
Street Address:	City:	State:	Zip:
Type of Treatment:	Length of Treatment:		
	Is the student still receiving services? ___Yes ___No		
Did the student benefit from this treatment? ___Yes ___No If yes, how? If no, why not?			

Provider Name:	Title/Specialty:		
Street Address:	City:	State:	Zip:
Type of Treatment:	Length of Treatment:		
	Is the student still receiving services? ___Yes ___No		
Did the student benefit from this treatment? ___Yes ___No If yes, how? If no, why not?			

Provider Name:	Title/Specialty:		
Street Address:	City:	State:	Zip:
Type of Treatment:	Length of Treatment:		
	Is the student still receiving services? ___Yes ___No		
Did the student benefit from this treatment? ___Yes ___No If yes, how? If no, why not?			

PAYMENT INFORMATION

Person responsible for payment:			Relationship to student:
Street Address:			Home Phone:
City:	State:	Zip:	Work Phone:
Driver's License Number:			Cell Phone:

If insurance is available for the student please complete the following:

Name of Insured:			Insurance Company:		
Student's Relationship to Insured:			Policy Number:		
Employer/Entity through which Insurance Provided:			Group Number:		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone Number:			Phone Number:		

GOALS

What would you like your child to achieve during the next 12 months?

_____

_____

_____

_____

_____

_____

_____

_____

_____

SIGNATURES

_____ _____ _____

Parent/Guardian Name Signature Date

_____ _____ _____

Parent/Guardian Name Signature Date