

AUTISM SERVICES FOUNDATION

STUDENT VOCATIONAL CAMP REGISTRATION

Client's Name: _____ Age: _____ Date of Birth: _____

Parents'/Guardians' Names: _____

Address: _____ City/State/Zip: _____

Mom:

Home #: _____ Work #: _____ Cell #: _____

E-Mail: _____

Dad:

Home #: _____ Work #: _____ Cell #: _____

I would like to sign up for: (please circle)

Session 1: week 1, June 22 – June 26

Session 1: week 2, June 2-July 3

Session 2: week 1, July 6-July 10

Session 2: week 2, July 13-17

Session 3: week 1, July 20-July 24

Session 3: week 2 July 27-July 31

Payment Information: Credit Card Check Regional Center Other

What was the Diagnosis? _____ When?: _____

Have there been prior educational assessments? Yes/No **Have there been prior legal assessments?** Yes/No

Have there been prior psychosocial assessments? Yes/No **Drug or Other Allergies:** _____

Necessary Medical Information: _____

Referring Physician (if any): _____ **Phone:** _____

Have you had Speech & Language evaluation? Yes/No

If yes, where and when? _____

What were the results? _____

Current Community Resources Utilizing: _____

Special Interests/Notes:(Food, Color, Sound likes and dislikes) _____
