

BRIDGES Social Skills Program

Registration Form (One form Per Child)

Child's name: _____ Male Female Age: _____ Grade: _____

Birth Date: _____ Home Phone: _____

Address: _____ City: _____

Zip: _____ School: _____

Parents/Guardians: _____

Work phone/cell: _____ Email(s): _____

Two sessions available. Please check the box(es) of choice.

Session 1: Weekdays June 25-29, 2012

Morning (8:30am-11am)

Afternoon (11:30am-2pm)

Full (8:30am-2pm)

Session 2: Weekdays August 13-17, 2012

Morning (8:30am-11am)

Afternoon (11:30am-2pm)

Full (8:30am-2pm)

Checks payable to: Bridges Educational Corporation

Mail payment and forms to:

Bridges Educational Corporation
Attn: Samantha Porter
5694 Mission Center Road
Suite 602, PMB 341
San Diego, CA 92108

The following deposit is required to be paid immediately to reserve a spot for **Session 1: June 25-29, 2012:**

\$200 non-refundable deposit for morning/afternoon class

\$400 non-refundable deposit for full day class

\$425 for morning/after class

\$800 for full class

\$ _____ for _____
(class(es) of choice)

The following deposit is required to be paid immediately to reserve a spot for **Session 2: August 13-17, 2012:**

\$200 non-refundable deposit for morning/afternoon class

\$400 non-refundable deposit for full day class

\$425 for morning/after class

\$800 for full class

\$ _____ for _____
(class(es) of choice)

Medical Information

Diagnosis: _____ Age: _____

Height: _____ Weight: _____

Allergies: _____

Special Diet/Feeding Restrictions: _____

Medications (administered by parents only): _____

Other medical concerns: _____

Information Required by State Law

Health Insurance Company: _____

Policy number: _____ Family Doctor: _____

Phone: _____ Address: _____

Health Record (check all that apply)

Diagnosis (Please attach proof of diagnosis of autism spectrum disorder – front page of IEP, statement from medical doctor or statement from other health professional.): _____

- Peanuts ADHD Bleeding Disorders Insect Sting
- Asthma Diabetes Penicillin Seizures Allergies

Explanation: _____

Is the child currently taking medications? Yes No

If so, please indicate: _____

Does the child have any hearing difficulties? Yes No

If so, please explain: _____

Does the child have any vision difficulties? Yes No

If so, please explain: _____

Description of any current physical, mental, or psychological conditions requiring medication, treatment or special restrictions or consideration while in the program: _____

_____ **I authorize** BRIDGES Education Corporation to apply sun block to my child if I supply the sun block. I understand that BRIDGES staff will apply the sun block when they deem necessary.

First Aid Consent

All BRIDGES instructors, supervisors and directors have received First Aid Training.

_____ I **authorize** all instructors, supervisors and directors of BRIDGES Educational Corporation to perform the necessary basic first aid for my child in the case of an emergency. I understand the basic first aid training does not include CPR certification.

Child Release Authorization/Emergency Contacts

Authorized persons, other than parents/guardians, to pick up child from the facility or to be called in case of emergency (Please list at least two):

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

Persons UNAUTHORIZED to pick up child from the facility:

Name	Relationship
_____	_____
_____	_____

Child in custody of/lives with: both parents mother father other: _____

Behavior Information: (Information will be used to place your child with the most appropriate staff)
Please check all that apply and be very specific.

- Aggressive behavior: Please explain: _____
- Behavior plan. Please attach.
- Sensory Diet/Plan: Please explain: _____
- History of Elopement: Please explain: _____
- Safety Concerns: Please explain: _____

Skill Information: **I = Independent** **SA = Some Assistance** **TA = Total Assistance**

(Circle one)

Explanation

Feeding: I SA TA _____

Toileting: I SA TA _____

Communication Information: (Please check all that apply.)

Expressive (Talking):

- Verbal Verbal (limited) Non-verbal Sign Language
 PECS Augmentative Device _____
 Other/Explanation: _____

Receptive (Understanding):

- Follows simple directions: Yes No Verbal Written Gestural
Uses visual schedule:
 Yes No Written Picture Object
 Other/Explanation: _____

Special Interests/Favorite Things: (Please list.)

Sports: _____ Toys: _____
Games: _____ Music: _____
Books: _____ Others: _____

Fears/Dislikes: (Please list.)

Goals:

Please tell us what your personal goals are for your child during the social skills program: _____

Photography/Publishing Release (if in agreement, please initial below)

- Bridges may photograph my child and use the photographs for promotional purposes. Yes No
Bridges may photograph my child and use the photographs for program activities. Yes No
Bridges may videotape my child and use the videotape for promotional purposes. Yes No
Bridges may videotape my child and use the videotape for training purposes. Yes No

* Note: Due to issues of confidentiality, parents are not allowed to take pictures of other children.

Participation Consent

_____ **I authorize** BRIDGES Educational Corporation to utilize an instructional program based on the principles and procedures of applied behavior analysis (ABA). I understand that such procedures may include prompting, shaping, chaining, discrete trial teaching (DTT), pivotal response treatment (PRT), reinforcement schedules, as well as behavioral reductive procedures, including extinction, differential reinforcement schedules, and punishment (e.g., time out from reinforcement, response cost) procedures.

_____ **I understand** I must follow the recommended health guidelines (which will be provided to me) for my child's participation in BRIDGES Social Skill Program and I will not allow my child to attend class if he/she is experiencing or has experienced in the last 12 hours certain medical conditions including but not limited to fever, vomiting, diarrhea, unidentified rash, pink eye, or any other infection. I understand that in some instances, a physician's note authorizing participation, during or after illness, may be required.

_____ **I authorize** BRIDGES Educational Corporation to use any data collected from my child's program, without restriction. Furthermore, I understand that data from my child's program within BRIDGES curriculum is the property of BRIDGES Educational Corporation. Such data may be combined with data from other children in the program, analyzed and then published in scientific journals or other publications. I understand that no identifying information regarding myself, my child, or any other child will be disclosed in any publication or presentation.

_____ **I understand** that my privacy and confidentiality is protected under the Health Insurance Portability and Accountability Act (HIPAA). However, there are certain limits of confidentiality. In the course of providing services to your child, if we become aware of any instances of suspected child abuse or neglect, we are obligated by law to report this to Child Protective Services (CPS).

_____ **I understand** that an adult responsible for the child must transport the child when needed. The employees of BRIDGES Educational Corporation may not transport a child under any circumstances. If a child's program requires teaching the child in a community setting, an adult responsible for the child must be present at all times and must transport the child when necessary.

_____ **I have received** the BRIDGES Social Skills Program handbook and understand that initialing here indicates that I have read and agree to comply with the policies of BRIDGES Social Skills Program.

Financial Responsibility:

_____ **I have received** the Bridges Social Skills Program handbook and understand that initialing here indicates that I have read and agree to comply with the policies therein regarding absences, fees, requirements and proper notification of taking my child out of Bridges Social Skills Program.

RELEASE/WAIVER FOR YOUTH (MINORS)

Name of Minor: _____

I, the undersigned parent/person having legal custody/guardianship of the above named minor, give permission for the minor to participate in BRIDGES Educational Corporation programs. The minor is physically able and mentally prepared to participate in all activities as described in the announcement for the program. In consideration of said minor being permitted to enter **Hage Elementary School** for observation, use of facilities and/or equipment, or participation of the above or any program, I, on behalf of myself (as parent, guardian, coach aide, spectator or participant) hereby:

1. Acknowledge that (i) I have read this document, (ii) I have inspected the facility and equipment, (iii) I accept them as being safe and reasonably suited for the purposes intended, and (iv) I voluntarily sign this document.
2. Release BRIDGES Educational Corporation, its directors, supervisors, employees, and volunteers (collectively "Releasees") from all liability to me for any loss or damage to property or injury or death to the above named minor, the minor's parent, and/or any parent/person having legal custody/guardianship of the minor, whether caused by Releasees or otherwise and while such minor is in or near BRIDGES Social Skills Program at **Hage Elementary School**.

3. I agree not to sue Releasees for any loss, damage, injury or death described above and I will indemnify and hold harmless Releasees an each of them from any loss, liability, damage or cost they may incur due to said minor's presence in, upon or near BRIDGES Social Skills Program at **Hage Elementary School**; whether caused by the negligence of Releasees or otherwise.
4. I assume full responsibility for, and risk of, bodily injury, death or property damage due to the negligence of Releasees or otherwise.
5. I do hereby authorize BRIDGES Educational Corporation as agent for the undersigned, to consent with respect to said minor, to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician and surgeon licensed under the provisions of the California Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that BRIDGES Educational Corporation is not responsible for costs incurred for medical care.

I intend this document to be as broad and inclusive as is permitted by the laws of the State of California; if any portion hereof is held invalid, I agree the remaining portions shall continue in full legal force and effect.

Name of Parent/Guardian (Print): _____

Parent/Guardian's Signature: _____ Date: _____