S.P.E.A.K. DATES FOR 2020

July 1   First student day, full day
July 2-3 In session
July 6-10 In session
July 13-17 In session
July 20-24 In session
July 27  In session
July 28  Last day – half day for students

Student Hours  9 a.m. to 2 p.m.
Staff Hours    8:15 a.m. to 2:15 p.m.
Location:      Steel Valley High School
               3113 Main Street
               Munhall, PA 15120
FOR SAFETY ATTACH RECENT PHOTO OF CHILD

REQUIRED Social Security Number:____________________

NAME OF CHILD_________________________BIRTHDATE________________AGE_____
ADDRESS______________________________________________________________________
Number Street/Avenue City/State Zip Code
Parent/Caregiver’s Names ______________________________________________________
Father Mother Other
Address _______________________________________________________________________
(if different from child’s)
Primary Phone __________________ Secondary Phone __________________
Emergency Contact ___________________________ Phone __________________
Name/Relationship **Email address:_________________________________________________________________
School District ___________________________Present School____________________
School Address ___________________________________Teacher’s Name______________
Service Coordination Unit_____________________________________
Address _______________________________________________________________________
Name of Caseworker ___________________________ Phone __________________
Is child diagnosed ASD? ______________ Other? __________________________
Who made diagnosis ______________________Where_____________When_________

Does your child qualify for Extended School Year (ESY)?____________________________
If not, can you provide or make arrangements for transportation for your child to attend SPEAK?___
T-Shirt Size____________________

IMPORTANT: PLEASE NOTE NEW ADDRESS

RETURN BY APRIL 20, 2020 TO: S.P.E.A.K. Program
Professional Bldg. 1, Suite 1106
11676 Perry Highway
Wexford, PA 15090
412-856-7223

Provider of Services for Autism Involved Individuals in the Greater Pittsburgh Area
2020 S.P.E.A.K. SUMMER PROGRAM
STUDENT INFORMATION FORM

To be completed by parent or caregiver

Child’s Name ___________________________________ Age ____ Date of Birth___________________

Parents/Caregiver’s Name _______________________________________________________________

Address_____________________________________________________________________________

Street/Avenue                                               City                               State              Zip Code

Home Phone Number ____________________Work #___________________Cell #_____________

Emergency Phone Number________________________Name/Relationship___________________

1. Is your child toilet trained? YES _____ NO ______

2. If toilet training is an emerging skill for your child, describe the toileting schedule that is used.

3. Can your child feed himself/herself? YES ______ NO_______

4. Are there any problems for your child when eating? YES ______ NO ______
   If yes, please specify.

   Food allergies? YES ______ NO _____ Dietary restrictions? YES ______ NO ______
   If yes, please explain.

5. Does your child have any particular fears? YES ______ NO ______
   If yes, what are they and how are they handled?

6. What forms of communication does your child use?

7. What oppositional behavior does your child display?

8. What are your child’s typical behaviors in community and on public transportation?
9. What intervention/reinforcement programs are used for these behaviors?

10. Does your child have a one-on-one aide assigned to him/her during the regular school year? YES ______ NO ______

11. Does our child have a TSS (Therapeutic Support Staff) person assigned to him/her?  
   AT HOME   YES ______ NO ______
   IN SCHOOL  YES ______ NO ______

   What agency provides your child's wraparound services?__________________________________________
   Contact/Supervisor's Name _____________________________________________________________
   Phone No. _______________________________________________

12. What kinds of activities or items are reinforcing for your child?

13. Would you be interested in participating in a family day? YES ______ NO ______

14. Is there anything else that you would like us to know about your child?

Please check the following recreation/leisure activities in which your family participates and you would like your child to learn:

- BASKETBALL ______ BASEBALL _______ FOOTBALL _______
- BOWLING ________ SOFTBALL ________ VOLLEYBALL ______
- RUNNING/JOGGING ______ SWIMMING ________ AEROBICS ______
- MINITURE GOLF _______

Which of the following are areas of interest for your child?

- MUSIC _____ ART _____ COMPUTERS _______ READING ______
- COOKING ___ CRAFTS __ MOVIES ___________ ANIMALS/PETS __
- OTHER _____________________________________________

Please check the following community activities in which your family participates and you would like your child to learn:

- SHOPPING ______ LIBRARY _______ MOVIE THEATRE _____
- ZOO ___________ RIDING BUS/SUBWAY ______ MUSEUM ____________
Do you have any particular problems when you attempt to have your child participate in these activities? (Please describe)

Describe your child’s behavior when crossing streets and walking on sidewalks.

APPLICATION FORMS MUST BE RETURNED BY **APRIL 20, 2020**
S.P.E.A.K. SUMMER PROGRAM
EMERGENCY MEDICATION DATA

Student _______________________________ Parent’s Name ____________________________
Address _________________________________________ School District __________________
Home Phone ___________________ Work # ___________________ Cell # ___________________
Person to contact in CASE OF EMERGENCY __________________________________________
Phone ___________________ Address ________________________________________________

Second Emergency Name ___________________________ Phone________________________

Family Physician _________________________________ Phone __________________________
MEDICATION: __________________________________________________________________

Does your child require medication regularly? If so, please list type and frequency.
If yes, give name, address and phone number of prescribing physician.
Name _________________________________ Phone _________________________________

Please note any allergies including any know drug allergy (use additional paper if necessary)

EMERGENCY TREATMENT
In the event of an emergency, you will be notified. However, if we are unable to contact you, we request permission for
the following: (1) use of antiseptics (2) notification of a local doctor if necessary and (3) transportation of your child to a
hospital if warranted.
I hereby give my consent to the above request to administer emergency treatment. I will assume responsibility for any
charges for the necessary treatment through insurance or by direct payment.

(Signature)____________________________________________________________________
2020 S.P.E.A.K. SUMMER PROGRAM

AUTHORIZATION FOR FIELD TRIPS

Circle One

YES  NO

To make it possible for my child to take full advantage of the S.P.E.A.K. Summer Program, I hereby give my permission for him/her to make field trips under the supervision of the S.P.E.A.K. staff.

Date ________________________________

Signature______________________________________________________________

Relationship to Child ____________________________________________________________

2020 S.P.E.A.K. SUMMER PROGRAM

AUTHORIZATION FOR PICTURES

Circle One

YES  NO  I hereby give permission for pictures and/or movies to be made of my child to be used or training professionals and/or parents.

YES  NO  I hereby give permission for picture and/or movies to be made to be used for public relations/publicity.

Date ________________________________

Signature______________________________________________________________

Relationship to Child ____________________________________________________________
2020 S.P.E.A.K. SUMMER PROGRAM

PARENTAL WAIVER TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

I hereby authorize the Autism Society of Pittsburgh, Inc. (S.P.E.A.K. Program) to secure or release to my child’s school:

________________________________________________________________________

And/or my child’s Base Service Unit ____________________________________________

Any information concerning (Child’s Name) ______________________________________

Date ______________________________

Signature ________________________________________________________________

Relationship to Child ____________________________________________________________________________
Must be COMPLETED and SIGNED by DOCTOR

CHILD HEALTH STATUS FORM
2020 S.P.E.A.K. SUMMER PROGRAM – Return by APRIL 20, 2020

CHILD’S NAME _____________________________________________________________

1. Is the child free of communicable diseases?
   Yes _______  No ______

2. Is the child physically able to participate in the S.P.E.A.K. Summer Program?
   Yes ______  No ______

Comments: (if any)
_______________________________________________________________________________
_______________________________________________________________________________

Current Medications and Dosages:
_______________________________________________________________________________
_______________________________________________________________________________

Will medications need to be given during camp session, 9 a.m. – 2 p.m.
   Yes ______  No ______

What medications: __________________________________________________________
When given ______________________________________________________________

Physician’s Signature _______________________________________________________
Date ____________________________

Physician’s Name __________________________________________________________
Address _________________________________________________________________
_______________________________________________________________________________

Telephone Number _________________________________________________________