S.P.E.A.K. DATES FOR 2021

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>July 5</td>
<td>First student day, full day</td>
</tr>
<tr>
<td>July 6-9</td>
<td>In session</td>
</tr>
<tr>
<td>July 12-16</td>
<td>In session</td>
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<tr>
<td>July 19-23</td>
<td>In session</td>
</tr>
<tr>
<td>July 26-29</td>
<td>In session</td>
</tr>
<tr>
<td>July 30</td>
<td>Last day – half day for students</td>
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Student Hours: 9 a.m. to 2 p.m.
Staff Hours: 8:15 a.m. to 2:15 p.m.

Location: Saint Therese of Lisieux School
3 St. Therese Court
Munhall, PA 15120
2021 S.P.E.A.K. SUMMER PROGRAM
APPLICATION FORM

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

(If different from child’s)

Father

Mother

Other

Address __________________________

Primary Phone __________________ Secondary Phone __________________

Emergency Contact __________________ Phone __________________

Name/Relationship __________________

**Email address: ____________________________

School District _____________________________ Present School __________________

School Address _____________________________ Teacher’s Name __________________

Service Coordination Unit __________________________

Name of Caseworker __________________________ Phone __________________

Is child diagnosed ASD? __________ Other? __________________________

Who made diagnosis? __________________________ Where? __________________ When? __________

Does your child qualify for Extended School Year (ESY)?  YES ____  NO ____

If not, can you provide or make arrangements for transportation for your child to attend SPEAK?

YES _____  NO _____

T-Shirt Size __________________

IMPORTANT: PLEASE NOTE NEW ADDRESS

RETURN BY MAY 28, 2021 TO:

S.P.E.A.K.
P.O. Box 296
Wexford, PA 15090
412-856-7223

Provider of Services for Autism Involved Individuals in the Greater Pittsburgh Area
2021 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 ___________ MUSEUM ___________ PARKS ______________

PLAYGROUND ______ RIDING BUS/SUBWAY ________________

RESTAURANT (specify) _____________________________________________

OTHER (specify) ___________________________________________________________________

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 MAY 28, 2021
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 _________________________

MEDICATIONS: ________________________________

Does your child require medication regularly? Circle One   YES   NO

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)______________________________________________

Year 2021
2021 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 __________________________________

2021 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 __________________________________
2021 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 ________________________________
CHILD HEALTH STATUS FORM
2021 S.P.E.A.K. SUMMER PROGRAM

Must be COMPLETED and SIGNED by DOCTOR

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 Name _________________________________________________________
(Print Clearly)

Address _________________________________________________________________
(Print Clearly)

Telephone Number _______________________________________________________
(Print Clearly)

Physician’s Signature __________________________________ Date ________________