



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

Summer Program for the Education of Autistic Kids

Program of the Autism Society of Pittsburgh



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

July 5	First student day, full day
July 6-9	In session
July 12-16	In session
July 19-23	In session
July 26-29	In session
July 30	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:	Saint Therese of Lisieux School 3 St. Therese Court Munhall, PA 15120
-----------	---



Summer Program for the Education of Autistic Kids

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 _____
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)? YES _____ NO _____

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

YES _____ NO _____

T-Shirt Size _____

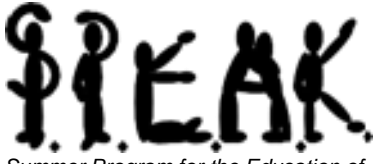
IMPORTANT: PLEASE NOTE NEW ADDRESS

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



Summer Program for the Education of Autistic Kids

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



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 _____

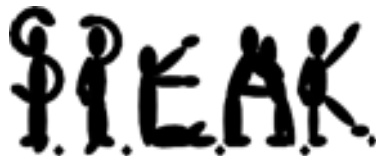
RESTAURANT (specify) _____

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



Summer Program for the Education of Autistic Kids

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



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 _____

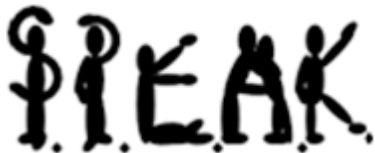
Please note any allergies including any know drug allergy (use additional paper if necessary)

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) _____



Summer Program for the Education of Autistic Kids

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



Return by: MAY 28, 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

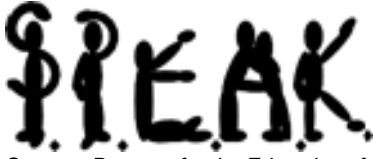
YES NO I hereby give permission for pictures and/or movies to be made of my child to be used or training professionals and/or parents.

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 _____



Summer Program for the Education of Autistic Kids

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

Year 2021



Return by: MAY 28, 2021

**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:

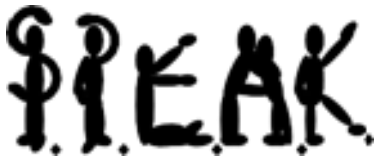
And/or my child's Base Service Unit _____

Any information concerning (Child's Name) _____

Date _____

Signature _____

Relationship to Child _____



Summer Program for the Education of Autistic Kids

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



Return by MAY 28, 2021

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 _____