



Social Skills Groups Registration Cover Page

Participant's Name:		DOB:	Age:	Grade:
Name(s) of Parent(s)/Caregiver(s):				
Address:		City:	State:	Zip:
Home Phone:		Cell Phone:	Email:	
Diagnoses:				
<input type="checkbox"/> New Participant		<input type="checkbox"/> Returning Participant		
Programs covered by RI Medicaid (Rite Care/Katie Beckett) A self-pay \$15.00 registration fee is required with this application. Total = \$15.00 even if applying for multiple programs. If you do not have Medicaid please contact Jill at 785-2666, ext. 1011 or jill@theautismproject.org for program pricing.				
<input type="checkbox"/> Take a Bite!		<input type="checkbox"/> Creative Expressions		
<input type="checkbox"/> Move & Groove <input type="checkbox"/> Johnston <input type="checkbox"/> Middletown		(at Figgy's Art Studio in East Greenwich)		
<input type="checkbox"/> Social Thinking <input type="checkbox"/> Johnston <input type="checkbox"/> Middletown		<input type="checkbox"/> Club Jr.		
Game On! <input type="checkbox"/> Karate <input type="checkbox"/> Basketball		<input type="checkbox"/> Club Jr.-Life Strategies		
<input type="checkbox"/> Leaps & Bounds		<input type="checkbox"/> The Club		
Programs covered by Hasbro Charitable Trust, United Way of Rhode Island, Doug Flutie Jr. Foundation, & the Billy Andrade - Brad Faxon Charities for Children:				
<input type="checkbox"/> Yoga		<input type="checkbox"/> Chill Zone* (Location varies)		
<input type="checkbox"/> Girls Night Out* (Location varies)		<input type="checkbox"/> Adult Community Group (Location varies)		
* Pre-requisite: Groups that meet off-site require prior approval from Project staff for participation.				
<input type="checkbox"/> Please check here if a Middletown site is preferred. (Social Thinking and Move & Grove groups)				
<i>Please complete the following information in the event that an emergency arises and we must contact you. Include information about how to reach you or another designated person during your child's group.</i>				
Emergency Contact Name		Relationship		Phone Number(s)
Emergency Medical Information				
Name of Physician:		City:	Phone:	
Please check all items that apply to child's present health. Thoroughly explain any checked answers.				
Allergies (list below): <input type="checkbox"/> No known allergies				
<input type="checkbox"/> Food (include any dietary restrictions):				
<input type="checkbox"/> Insects/Plants:				
<input type="checkbox"/> Medicine Allergies:				
Treatment for any of the above that The Autism Project may need to do):				
Medications my child is taking:				
<i>In case of emergency, I understand that every effort will be made to contact me or the contact people listed above. If I cannot be reached, I understand that staff will use a standard 911 protocol.</i>				
Signature of parent/guardian:			Date:	
Printed name of parent/guardian:				