



## 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		
<p><b>Programs covered by RI Medicaid (Rite Care/Katie Beckett)</b> A self-pay <b>\$15.00 registration fee</b> is required with this application. Total = \$15.00 even if applying for multiple programs. If you do not have Medicaid please contact Sue at 785-2666, ext. 1005 or <a href="mailto:sueconrole@theautismproject.org">sueconrole@theautismproject.org</a> for pricing.</p>				
<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		
Game On! <input type="checkbox"/> Karate <input type="checkbox"/> Basketball		<input type="checkbox"/> Club Jr.		
<input type="checkbox"/> Leaps & Bounds		<input type="checkbox"/> Club Jr.-Life Strategies		
		<input type="checkbox"/> The Club		
<p><b>Programs covered by Hasbro Charitable Trust, United Way of Rhode Island, Doug Flutie Jr. Foundation, &amp; the Billy Andrade - Brad Faxon Charities for Children:</b></p>				
<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)		
* <b>Pre-requisite:</b> 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>				
<b>Emergency Contact Name</b>		<b>Relationship</b>		<b>Phone Number(s)</b>
<b>Emergency Medical Information</b>				
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:				



## The Autism Project Social Skills Program PARTICIPANT PROFILE

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Participant's Name		DOB	Date
CEDARR? <input type="checkbox"/> Yes <input type="checkbox"/> No	Agency:	HBTS? <input type="checkbox"/> Yes <input type="checkbox"/> No	Agency:
Please complete the following sections and provide as much detail as possible. This information will help us create a successful group experience for your child. Please indicate your child's abilities in each of the following areas:			
Child's Likes:		Child's Dislikes:	
(favorite movies, characters, foods, games, music...etc) (sounds, smells, touch, movement, foods etc...)			
<b>Does your child use any of the following?</b>			
<input type="checkbox"/> Visual schedules <input type="checkbox"/> Social Stories <input type="checkbox"/> Conversation Scripts <input type="checkbox"/> Choice Zone Worksheet <input type="checkbox"/> Problem Solving Worksheets <input type="checkbox"/> Contingency Mapping <input type="checkbox"/> Thera-tubing <input type="checkbox"/> Fidgets: _____ <input type="checkbox"/> Headphones: _____ <input type="checkbox"/> Chewing Gum <input type="checkbox"/> Brushing Protocol <input type="checkbox"/> Weighted Blanket/Vest <input type="checkbox"/> Joint Compressions <input type="checkbox"/> Relaxation Protocols: _____ <input type="checkbox"/> Other:			
<b>Please describe your child's toileting</b>			
	Complete Assistance	Partial Assistance	Independent    Comments:
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>My child exhibits the following behaviors:</b>			
<input type="checkbox"/> Runs away <input type="checkbox"/> Touches other inappropriately <input type="checkbox"/> Scratches, bites, hits self <input type="checkbox"/> Scratches, bites or hits others <input type="checkbox"/> Screams <input type="checkbox"/> Other:			
<b>Does your child exhibit any of the following? If yes, please describe.</b>			
Self-stimulatory behaviors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Perseverative play or rituals?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Reaction to change?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
What is helpful in calming these actions?			

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Participant Name:

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<b>EMOTIONAL DEVELOPMENT</b>		
<b>Does your child:</b>	<b>Yes/No</b>	<b>Comments</b>
Request a break when upset?		
Express feelings?		
Indicate relaxation?		
Request assistance?		
Indicate likes/dislikes?		
Express confusion ("I don't know")		
<b>SOCIAL DEVELOPMENT</b>		
<b>Does your child:</b>	<b>Yes/No</b>	<b>Comments</b>
Engage in solitary play?		
Play same toy along side peers?		
Engage in group play?		
Share materials?		
Turn take with peers?		
<b>COMMUNICATION</b>		
<b>Does your child:</b>	<b>Yes/No</b>	<b>Comments</b>
Follow non-verbal directions?		
Follow verbal directions within familiar routines?		
Follow verbal directions within novel activities?		
Utilize visual supports to follow directions?		
Require processing time to follow directions?		
Use pictures/sign/ or other augmentative communication		
Comment on environment or the unexpected (oops!)?		
Make requests for basic wants and needs?		

Participant Name:

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Call attention to others?		
Converse with peers/ adults?		

**ORGANIZATION & TRANSITION**

Does your child:	Yes/No	Comments
Make transitions?		
Recognize personal belongings?		
Organize needed materials for outings?		
Make choices?		
Wait when directed?		

**COMMUNITY SKILLS**

Does your child go to:	Yes/No	Challenging Behaviors
Grocery Store		
Fast Food Restaurant		
Sit Down Restaurant		
Movies		
Organized Sports		

Adapted from Kathleen Ann Quill's Assessment of Social and Communication Skills for Children with Autism

Please describe your child socially. Include age of peers he/she enjoys; interests; games enjoyed; activities enjoyed; speaking style; etc.






Date: \_\_\_\_\_

Dear Participant,

This is a survey we need you to complete once every year in order to report statistical and demographic information for a United Way grant that supports this program and to fulfill data requirements for future grant opportunities. Please take a few minutes to fill out the survey below. No names are required and all information will be kept strictly confidential. Thank You!

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## Direct Service Programs Demographic Survey

### Participant's Information

Sex of participant  Male  Female

Participant's Age: \_\_\_\_\_

Participant's Primary Language  English  Spanish  Portuguese  Non-verbal

### Primary Diagnosis

- Autism  Asperger Syndrome  Childhood Disintegrative Disorder  
 High Functioning Autism  Fragile X  Retts Syndrome Disorder  PDD  
 PDD-NOS  Non-Verbal Learning Disorder

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### Family's Information

Number of people living in the household \_\_\_\_\_

- 0-20,000  10,000-25,000  26,000-50,000  51,000+

### Nationality

- African  African American/Black  Asian  Asian American/Pacific Islander  
 Cape Verdean  Caribbean  Caucasian/White (non-Hispanic)  
 Hispanic/Latino  Native American  Portuguese  Multi-Racial/Multi-Ethnic  
 Other (please specify): \_\_\_\_\_  Information Not Available

Primary Language  English  Spanish  Portuguese  Other: \_\_\_\_\_

Office Only:      Group Attended:
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## Social Skills Program

### PAYMENT INFORMATION

<b>Participant Name:</b>	
<b>Parent Name:</b>	
<b>Billing Address:</b>	
<b>City:</b>	<b>State:</b>
<b>Zip:</b>	
<b>Method of payment for Registration Fee</b> <input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Visa/MasterCard/Discover	
For Credit cards, Card #	Exp. Date:
Cardholder's Name:	
Cardholder's Billing Address:	
<b>Method of payment for Program Fee</b> <input type="checkbox"/> RI Medicaid/Katie Beckett (please include copy of card)	
<input type="checkbox"/> Self-pay (check website for prices) <input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Visa/MasterCard/Discover	
For Credit cards, Card #	Exp. Date:
Cardholder's Name:	
Cardholder's Address:	
<i>I authorize The Autism Project to process my payment as indicated above.</i>	
Parent/Guardian Signature:	Date:

<b>FOR OFFICE USE ONLY</b>	
Payment Received: ___ / ___ / ___ \$___	Initials: _____ Katie Beckett Approved: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a





## Social Skills / Camp Programs PERMISSION TO PHOTOGRAPH

Participant:	DOB:
<p>Thank you for your interest in the Autism Project's social skills program. We are always striving to provide the best in innovative and meaningful programs designed for children with autism spectrum disorders, and to provide the highest quality support and education for parents and professionals. In this spirit, we are pleased to be able to be a training site for students and professionals throughout our community.</p> <p>To ensure a productive and enjoyable experience for both students and educators, we are adopting an OPEN PICTURES POLICY. Children attending groups and camp may have their pictures taken throughout the day. In addition to using photos and videos for training purposes, please be advised that photos may be used for program development and marketing purposes, including but not limited to newspaper articles, television promotion, brochures, and other Autism Project advertising vehicles.</p> <p>Thank you for your cooperation with this policy and willingness to share your child's experiences.</p>	
Signature of parent/guardian:	Date:
Printed name of parent/guardian:	



## Social Skills / Camp Programs PERMISSION FOR RESTRICTIVE PROCEDURES

Participant:	DOB:
<p>The Autism Project uses evidenced-based strategies that are designed to establish a supportive and safe environment that will prevent your child from having behavioral difficulties. However, there may be rare occasions when the physical safety of the child, other participants, and staff is at risk. When this type of incident occurs it may be necessary to physically hold your child to prevent harm, and to help her/him feel safe. Trained staff will only use a therapeutic hold in which your child is seated in a chair or on the floor and held in a "wrap" from behind. The hold is only maintained for as long as it takes for your child to begin to regain emotional and physical control so that s/he can move to a quieter area until they are able to rejoin the group. If it is necessary to move your child to a safe area before s/he has regained control, two staff will use an approved escort procedure. These procedures are carried out in a calming, supportive, and non-punitive manner. You will be notified when you pick up your child of the intervention so that you can assist staff in processing the incident and supporting your child.</p>	
<p><i>I understand that the above procedures will be implemented only for the purpose of safety and control and in accordance with the stated guidelines. I authorize that the seated wrap or two person escort will not compromise the medical safety of my child.</i></p>	
Signature of parent/guardian:	Date:
Printed name of parent/guardian:	



## Social Skills Program PERMISSION TO PICK UP CHILD

Child:	DOB:		
Parent:	Date:		
Address:	Phone:		
<p>Please complete the following information in the event that someone other than yourself may pick up your child from a social skills group. You must notify us in advance of who will be picking up your child. Please note that we may ask that person to present identification to verify their identity before releasing your child to her/him</p>			
Name	Address	Relationship	Phone #
Signature of parent/guardian:			Date:
Printed name of parent/guardian:			