



# The SOAR Experience

*A therapeutic social skills program in a summer day camp-like environment for children with Asperger's Syndrome and related disorders*

## Asperger's Related Services

### **APPLICANT APPLICATION AND REGISTRATION FORM (2010)**

Completion of this form is necessary for admittance to The SOAR Experience.

In addition, prospective applicants who are new to West Bergen may be interviewed by senior staff to determine if the child will benefit from the summer program.

\*APPLICATION DEADLINE: JUNE 25, 2010

#### *1. Applicant Information*

The Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: ( ) M ( ) F

Grade: \_\_\_\_\_ School: \_\_\_\_\_ Sending District: \_\_\_\_\_

Home Address:

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Street                                      Apt#                                      City                                      State                                      Zip Code

Language(s) Spoken at home: \_\_\_\_\_ Does a parent speak English? Yes ( ) No ( )

Parent's marital status: \_\_\_\_\_

Please list every member of the household:

NAME	DATE OF BIRTH	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The applicant is

Presently a client at West Bergen     A former client at West Bergen     Not and has never been a client at West Bergen

**2. Family Information:**

Parent-Guardian #1

Parent-Guardian #2

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to the applicant

\_\_\_\_\_  
Address  
( ) \_\_\_\_\_  
Home Phone  
( ) \_\_\_\_\_  
Work Phone  
( ) \_\_\_\_\_  
E-Mail (Please print clearly)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to the applicant

\_\_\_\_\_  
Address  
( ) \_\_\_\_\_  
Home Phone  
( ) \_\_\_\_\_  
Work Phone  
( ) \_\_\_\_\_  
E-Mail (Please print clearly)

How did you find out about our program?

\_\_\_\_\_

**3. Emergency Contacts:**

Please identify **at least 2 and up to 4** people (**other than parent/guardian listed on previous page**) who may be called between 9 AM and 3 PM when you are not available.

Name:	Telephone:	Relationship to child:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**4. Trip Permission**

I give my child permission to take walking trips and bus trips with the West Bergen SOAR Staff.  
( ) Yes ( ) No

**5. Dismissal Procedure**

Parents are encouraged to pick up their child, if walking is not an option.

I give my child, who is 12 years of age or older, permission to walk home alone at dismissal time – 3:00 PM.  
( ) Yes ( ) No

People permitted to pick up my child:

Name	Relationship to Child	Day- Time Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**If you do not want your child picked up by a specific adult, please answer all of the following questions (A-C).**

A. My child **MAY NOT** be picked up by the following individual because there is an active order of protection  
Name \_\_\_\_\_ Docket # \_\_\_\_\_ Expiration Date \_\_\_\_\_

B. My child is aware of this order and will report this adult to a West Bergen Staff member  
( ) Yes ( ) No

C. I realize that there is no easy way of monitoring who picks up my child after the program. If I think this may be a problem, I will make an appointment with the SOAR Director at 201-934-1160 to set up a special procedure for dismissal.

( ) Yes, I think there may be a problem ( ) No, I do not anticipate any problems

**6. About Your Child** (please use separate page if necessary)

Child's strengths:

Child's Challenges:

Child's social communication ability (i.e. how often does your child appropriately and successfully initiate, maintain and end conversations with others, how does your child do communicating one on one vs. in a group setting, etc.) :

Child's play activity and peer relationships (what does s/he like to play with, special interests, how s/he does with peers, types of relationships in his/her life, etc.):

Identify all sensory, motor, behavioral, nutritional or additional issues that would help us to work more effectively in making this a successful experience for your child:

Has your child had any incidents of aggression and/or self-injurious behavior at school, home or community during the last 12 months? Please describe.

Have there been any hospitalizations during the child's life for social-emotional-behavioral issues? This includes PESP visits, Emergency Room visits, emergency risk assessments of visits from Children's Mobile Crisis. If yes, please state when and describe briefly.

**7. Release and Authorization**

I give permission to SOAR program staff and West Bergen Mental Healthcare or its agents to obtain education/psychological/medical/service information from my child’s school, other educational sources, doctors, therapists, counselors, or other professionals if necessary in order to evaluate applicant’s acceptance and placement. This authorization shall be effective until revoked by me in writing and delivered to the West Bergen Mental Healthcare, The SOAR Experience Director.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**8. Photo/Video/Interview Consent**

*Please note: Sometimes children want to be in photos or videos when parents have not given permission. Under those circumstances, children feel excluded when asked to move out of the camera lens view. We may have activities that involve photos and video.*

**Note:** The use of the term “non-identifying” in the selections below is being used to indicate that your name would not be used or attached to the photograph.

\*I understand that The SOAR Experience features special events both in the facility and away from the facility where photos or videos may be taken. In addition, part of the social skills programming requires video taping applicants practicing their skills and then reviewing those tapes. Please indicate your preference with regard to photos and videos by checking the choices below (Please initial all that apply):

- \_\_\_\_\_ I agree to allow my child to be photographed for the child to bring home
- \_\_\_\_\_ I agree to allow my child to be photographed for use within the groups at the program
- \_\_\_\_\_ I agree to allow my child to be in a video for use within the groups at the program
- \_\_\_\_\_ I agree to allow my child to be in a non-identifying photograph that may be used in a West Bergen presentation aimed at increasing awareness and educating others
- \_\_\_\_\_ I agree to allow my child to be in a non-identifying video that may be used in a West Bergen presentation aimed at increasing awareness and educating others
- \_\_\_\_\_ I agree to allow my child to be in a non-identifying photograph that may be used in a West Bergen publication
- \_\_\_\_\_ I agree to allow my child to be in a non-identifying video that may be used in a West Bergen fund-raising video

The undersigned, on his or her own behalf and on behalf of the child, as well as on behalf of all of the Undersigned and Child’s heirs, successors and/or assigns, does hereby release WBMHC and its and their heirs, successors, and/or assigns from any and all claims, demand, and liability of whatever kind, including but not limited to payment of any compensation, for misappropriation or misuse of any publicity, trademark, copyright, or other rights of the Child and/or Undersigned and their heirs, successors and/or assigns, arising out of photographs/video of you or your child.

\* \_\_\_\_\_  
**Parent/Guardian**

\_\_\_\_\_  
**Date**



**11. Other Provider Information (if applicable)**

Case manager: _____	Therapist: _____
Address: _____	Address: _____
Reason For Service: _____	Reason For Service: _____
City: _____ ST: _____ Zip: _____	City: _____ ST: _____ Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

**12. Diagnostic and Classification Information:**

Psychiatric Diagnosis: \_\_\_\_\_

Educational Classification: \_\_\_\_\_

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**\*Copies of most recent diagnosis and evaluations, including IEP (if classified) MUST accompany this application**

Diagnostic evaluation \_\_\_\_\_

Evaluations attached – Identify \_\_\_\_\_

IEP attached (**Please include all evaluations and reports used to generate the IEP**)

**13. Emergency Medical Care**

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. If my child requires emergency medical care and I cannot be reached, I give my consent to The SOAR Experience and West Bergen Mental Healthcare to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child received. I understand that every effort will be made to contact me before and after medical care is provided.

Parent/Guardian

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

2. Health/Insurance Information:

CIT Applicant's Primary Doctor: \_\_\_\_\_ (Fill in all information on this physician in 1st box below)

Insurance Company: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Religious Preference: \_\_\_\_\_

**13. Other Medical Information:**

*If accepted, please attach a letter to this application from applicant's primary physician stating the applicant's general health, any medical conditions, medications prescribed and vaccination status. For those taking medication, you will be required to produce prescription documentation for medication distribution onsite and medication must come to the site in the original container.*

Applicant's Primary Physician:	Applicant's Other Doctor:
Type of Physician: _____	Type of Physician: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

**14. Medication(s) and Dosages(s):** \_\_\_\_\_

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**15. Food Allergies, Dietetic needs, other allergies**

- The applicant has no known food allergies and/or other restrictions.
- The applicant has the following food allergies and/or food restrictions: \_\_\_\_\_

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- I give permission for my child to eat meals or snacks provided by the program
  - I do not give permission for my child to eat meals or snacks provided by the program. My child will bring his/her own snack and lunch.
  - My child knows not to eat the foods mentioned below and will ask about the ingredients of a particular food if he/she is unsure of the contents.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

