Easter Seals Respite Services
Registration Form

Parent/Caregiver Name: ____________________________________________

Street Address: ____________________________________________ Apt: ______________________

City: ______________________ State: _____ Zip: _________________

Phones: Home: ______________________ Cell: ______________________

E-mail Address: ____________________________________________

Please complete this information about your child who has a special need or disability who will be attending the in-center event.

Child’s First Name:_____________ Last Name:_____________ Nickname:_____________

Gender:  □ Male       □ Female       Birthday: __________

School Setting: □ No School       □ Home School       □ Day care       □ Pre-school
□ Elementary       □ Middle/junior high       □ Special Education

Special Needs/Diagnosis: □ ADHD       □ Autism       □ Behavioral Challenge
□ Cancer       □ Cerebral Palsy       □ Down Syndrome       □ Emotional Disability
□ Learning Disability       □ Intellectual Disability       □ Other: ______________________

Details: What affect has this condition had on your child? Motor skills, communication, personality, behavior
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Child’s Allergies: ______________________

Child’s Medications: ______________________

Child uses assistive device (type)________________________ for________________________

Key Child Comments: Ex: verbal skills, motor skills, communication skills, personality, eating issues
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Has your child participated in group activities before (i.e. through school or another organization)? If so, how did they handle/react to the interaction?
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

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Can your child participate in the activity with a small group (2-3 total) of children?

Does your child have a history of running off? Please explain.

Does your child have any behavioral problems that we should know about? How should we best deal with these concerns?

SOCIALIZATION

Activities that my child enjoys or promotes success:

My child adjusts to new people in the following way and here are some steps/activities to help:

My child transitions to new or different activities in the following way(s):

COMMUNICATION

My child communicates in the following way(s):

The child might “test” you or “push your limits” by __________________________. What to do if this happens:

These activities typically frustrate/anger/present a challenge to my child:
Please complete this information about any SIBLINGS that will also be attending the respite trip.

Child’s First Name: ______________ Last Name: ______________ Nickname: __________

Gender:  ☐ Male  ☐ Female  Birthday: _________

School Setting:  ☐ No School  ☐ Home School  ☐ Day care  ☐ Elementary  
                 ☐ Middle/junior high  ☐ Special Education

Child’s Allergies: ________________________________________________________________

Child’s Medications: ____________________________________________________________

Has your child participated in group activities before (i.e. through school or another organization)? If so, how did they handle/react to the interaction?

Does your child have any behavioral problems that we should know about? How should we best deal with these concerns?

SOCIALIZATION

Activities that my child enjoys or promotes success:

My child adjusts to new people in the following way and here are some steps/activities to help:

My child transitions to new or different activities in the following way(s):

COMMUNICATION

My child communicates in the following way(s):
EMERGENCY INFORMATION

Parent/Caregiver Name: ____________________________________________

Child name(s): ___________________________________________________

Cell: __________________________

Please provide us with at least one emergency contact person.

First Name: ___________________________ Last Name: ___________________________

Relation: __________________________

Phones: home ___________ cell ___________ alternate ___________

Street Address: ____________________________ Apt. # ______

City: __________________________ State: ______ Zip: __________

Child’s Primary Physician

First Name: ___________________________ Last Name: ___________________________

Phone: __________________________

Street Address: ____________________________ Suite # ______

City: __________________________ State: ______ Zip: __________