

Registration & Information Form

PLEASE PRINT CLEARLY

Student Name _____

Student Age _____ Birth Date ____/____/____ Grade in Sept. 2017 _____

School attending for 2016/17 year _____

Parent / Guardian Name(s) _____

Parent / Guardian Cell Phone _____

Parent / Guardian Email _____

Parent / Guardian Work Phone _____

Street Address _____

City _____ State _____ Zip Code _____

How did you hear about this program? _____

Health Insurance Carrier and Number _____

Doctor's Name _____ Phone _____

PERSON TO CONTACT IN AN EMERGENCY *if Parent/Guardian is not available:*

Name _____ Cell Phone _____ Relationship _____

Please describe any relevant medical conditions, including medications taken on a regular basis.

Does your child have any allergies and/or dietary restrictions? If yes, please describe.

Participants must be completely independent with their toileting needs. Does this describe your child? Yes No

Does your child have a 1:1 classroom assistant? Yes No

SOCIAL / EMOTIONAL (please check all that apply to your child)

My child has difficulty:

- | | |
|---|--|
| <input type="checkbox"/> Engaging in play or leisure activities with peers | <input type="checkbox"/> Identifying problems / conflict |
| <input type="checkbox"/> Taking turns / sharing | <input type="checkbox"/> Identifying solutions and potential consequences to problems / conflict |
| <input type="checkbox"/> Maintaining personal space of self / others | <input type="checkbox"/> Recognizing his / her own emotions |
| <input type="checkbox"/> Commenting on the environment to others (describes, labels, names) | <input type="checkbox"/> Recognizing others' emotions |
| <input type="checkbox"/> Engaging in activities that are not highly preferred | <input type="checkbox"/> Utilizing appropriate coping strategies when upset |
| <input type="checkbox"/> Recognizing how his / her behavior affects others | |

COMMUNICATION LEVEL (please check all that apply to your child)

My child:

- | | |
|---|---|
| <input type="checkbox"/> Is verbal | <input type="checkbox"/> Follows verbal / nonverbal directions |
| <input type="checkbox"/> Is nonverbal | <input type="checkbox"/> Utilizes visual supports to follow directions |
| <input type="checkbox"/> Uses an augmentative communication system / device | <input type="checkbox"/> Indicates his / her likes and dislikes |
| (please specify): _____ | <input type="checkbox"/> Makes requests for his / her basic wants and needs |

CHALLENGING BEHAVIORS (please check all that apply to your child and describe as needed)

My child may:

- Run away _____
- Act aggressively towards self/others _____
- Shut down / withdraw _____
- Be non-compliant _____
- Is self-injurious _____
- Other _____

What behavior modification strategies do you suggest we use with your child? (Praise, material reinforcers, token system, etc.)

SENSORY (please check all that apply to your child)

My child:

- | | |
|--|---|
| <input type="checkbox"/> <u>Avoids</u> or <u>seeks</u> touch from others (please circle which) | <input type="checkbox"/> Seems to be in constant motion (loves spinning, swinging, being upside down, etc.) |
| <input type="checkbox"/> <u>Avoids</u> or <u>seeks</u> messy play such as playdoh, glue, and paint (please circle which) | <input type="checkbox"/> Cannot process or tolerate extremes of intensity such as color, light etc. |
| <input type="checkbox"/> Plays rough in play / leisure activities | <input type="checkbox"/> Is over or under sensitive to sounds (please circle which) |
| <input type="checkbox"/> Avoids participation in sports or active games | <input type="checkbox"/> Eats non-edible items |
| <input type="checkbox"/> <u>Craves</u> or <u>avoids</u> movement (please circle which) | <input type="checkbox"/> Dislikes strong smells/tastes |

What are your child's favorite activities or interests that can be used to reinforce good behavior? (movies, characters, foods, games, music, etc)

Does your child have any specific dislikes? (sounds, smells, touch, movement, foods, etc)

What are some great things about your child that you would like us to know?

Time-Out Procedure

Two River Spectrum Theater classes use evidenced-based strategies that are designed to establish a supportive and safe environment. There may be times when a participant may feel overwhelmed, or rare occasions when the safety of class participants and/or staff is at risk. When this type of incident occurs it may be necessary to implement a time-out procedure. The goal of applying this procedure is to decrease the future occurrence of a target behavior. At Two River Theater, we will utilize two types of time-out: "exclusionary" and "non-exclusionary". **Exclusionary Time-Out** will include one of two methods - utilizing our Time-Out Room (time-out in a room attached to the classroom, created specifically to calm and relax the student until they are ready to rejoin the class), or a Hallway Time-Out (student goes outside the classroom with an aid, and stays in the hallway or lobby until they are ready to rejoin the class.) **Non-Exclusionary Time-Out** includes contingent observation, when the child must sit and watch others engage in reinforcing activities until he/she is able to rejoin the class. These procedures are carried out in a calming, supportive, and non-punitive manner.

Ages 10-13

Monday, July 17 – Friday, July 21 9:30am-10:30am \$150

If your child responds positively to the class, and if demand allows, might you be interested in a second week (July 24-28)?

Yes

Maybe

No

If 'Yes' or 'Maybe', what is the most efficient way to reach you?

Email: _____

Cell: _____

Other: _____

Ages 14-17

Monday, July 17 – Friday, July 21 11:00am-12:00pm \$150

If your child responds positively to the class, and if demand allows, might you be interested in a second week (July 24-28)?

Yes

Maybe

No

If 'Yes' or 'Maybe', what is the most efficient way to reach you?

Email: _____

Cell: _____

Other: _____

Total: \$ _____

See last page for Payment Info.

