ANNUAL ADMISSIONS FORM FOR

SENSATIONS THERAFUN PROGRAM PARTICPATENT

(Not required for annual or daily play pass holders)

Participant's Name _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Gender: M____ F____ Date of Birth _____ Age as of June _____

Family Information:

Guardian's Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

2nd Parent's Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Authorized Pick up ☐ Parent's and emergency contacts listed may pick up my child

Additional people who can pick up _____ _____

Unauthorized to pick up _____ _____

Emergency Information

Emergency Contact _____ Relationship _____ Phone: _____

To help our staff understand your child's needs tell us about your child:

Child's diagnosis: _____

Child's strengths: _____

Child's difficulties (academic, social, behavioral, emotion): _____

_____

Tell us about your goals for your child: _____

_____

Known allergies: _____

Current medication (s): _____

Physical difficulties: _____

Motor functioning: _____

Sensory integration issues: _____

Tell us about the types of situations that your child finds challenging and tell us what you have found to effective to manage the situation? _____

_____

Tell us about the activities that you may use to help soothe and calm your child?_____

_____

What physical/verbal signs des your child exhibit when he/she is becoming anxious and what works to help manage the situation? _____

_____

Describe your child's ability to communicate:

_____

_____

Please list your child's treatment history:

_____

_____

Does your child have a history of any of the following:

Physical aggression: ☐ Yes ☐ No
Requiring physical restraint: ☐ Yes ☐ No
Self-harm or ideation: ☐ Yes ☐ No
Behavior dangerous to self or others: ☐ Yes ☐ No
Emotional aggression: ☐ Yes ☐ No
Sexual acting out: ☐ Yes ☐ No
No running away: ☐ Yes ☐ No
Difficulty with toileting: ☐ Yes ☐ No

If the answers to any of the above are yes, please describe:
Last instance: Frequency:
Intensity: Duration:

Are there any other issues you feel we need to be aware of?

_____

_____

_____

I, the undersigned, am the parent/legal guardian of_____, who is enrolled in Sensations TheraFun Programs. I understand that 100% refund of fees are available if I cancel 6 weeks out of the program beginning, 50% of my payment is refundable after canceling 30 days prior to the program beginning and no refunds are available due to my canceling less than 30 days of the program starting.

Parent/Guardian Signature_____ Date _____

ANY OTHER IMPORTANT INFORMATION FOR SENSATIONS THERAFUN STAFF AND IT'S PROGRAM PARTNERS TO KNOW PLEASE USE THE BACKSIDE IF NECESSARY. Thank you!