Hope for Three
Sibling Sessions & Parents Time Out
Registration

Parent Name(s): ____

Cell Phone: ___________________________ Alternate Cell: ______________________________

E-mail: ______________________________ Alternate E-mail: _____________________________

Complete to Register for Sibling Sessions

Child's Name: _________________________________ Preferred Name: __________________

Birth Date: ______________________ Age: ________ Gender: __________________

School: ____ Grade: ___________________

Hobbies/Interests: ____

____

Favorite Movie: ____

Likes: ____

Favorite Subject in School: ____

Dislikes: ____

Allergies: ____

Special Needs: ____

Health Restrictions: ____

Additional Notes or Comments

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Complete to Register for Parents Night Outs

Name of child on the autism spectrum: ____

Preferred Name: ____

Birth Date: _________________________ Age: ____________ Gender: ___________________

School: ____

How does this child communicate? Example: verbally, sign language, PECS, gestures only.

____

Is this child toilet trained? ___________ How do they let you know they need to go to the restroom?

____

Special Needs: ____

Health Restrictions: ____

Is this child allergic to anything that they may come in contact with at PTO? ______ Yes ______ No

If yes, specify. ____

Are there any behaviors that this child might engage in that we should know about? eg. Running away from adults, aggression to adults or peers, putting things in their mouth, etc. _____ Yes _____ No

If yes, specify. ____

Provide any other information that you feel would make PTO more enjoyable for your child on the autism spectrum ____

Additional Notes or Comments

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