



**FRIENDSHIP SKILLS LEVEL 1 or 2  
PARTICIPANT INFORMATION**

**Appendix G**

PLEASE PRINT CLEARLY

609 - 25<sup>th</sup> Street East  
Saskatoon, SK S7K 0L7  
Phone: (306) 665 – 7013  
Fax (306) 665 – 7011  
Email: admin@autismservices.ca

**PARTICIPANT Media consent given: \_\_\_\_ Yes \_\_\_\_ No**

Name: \_\_\_\_\_

(First, Last)

Date of Birth: \_\_\_\_\_

Diagnosis	Approximate Date of Diagnosis
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Does the participant know he / she has a form of autism spectrum disorder?  YES  NO

- As a parent what are your goals in registering your child in Friendship Skills?
- What are your child's strengths and challenges in developing and maintaining friendships?
- Does your child feel that they are struggling with developing or maintaining friendships?
- What would your child say are their strengths and challenges in developing or maintaining friendships?
- Has your child participated in any other friendship or social skills program? If so, please describe.
- Is there anything we should know about your child so that we can help him/her have a successful and positive experience?
- Are you willing to commit to weekly parent component homework?

Date	Parent/Guardian Name (Please Print)	Parent/Guardian Signature