Kindergarten Transition Registration

Autism Services of Saskatoon

Email: registration@autismservices.ca (PDF forms accepted only!)

Mail: 209 Fairmont Dr. Saskatoon, SK S7M 5B8

Deadline for All Registration Forms/Applications: Wednesday, May 27th at 4pm

Are you a Member? ◯Yes ◯No Name of AIP Consultant (if applicable): _____

Participant Registration Information *Please print legibly*

NAME:_____ AGE: _____ BIRTHDAY: _____ MALE◯ FEMALE◯

MOTHER/GUARDIAN 1: _____ FATHER/GUARDIAN 2: _____

ADDRESS:_____ CITY:_____ POSTAL CODE:_____

EMAIL ADDRESS:_____ Autism Services uses email as our primary form of contact. By not providing an address you may miss out on important information.

HOME PHONE:_____ EMERGENCY CONTACT:_____

MOM'S (1) CELL:_____ EMERGENCY PHONE:_____

DAD'S (2) CELL:_____ RELATION TO CLIENT:_____

Participant Health Information

THIS CHILD ◯has ASD diagnosis? ◯on WAIT LIST for ASD diagnosis? ◯Neurotypical Child (No ASD Diagnosis)

CLIENT CARRIES AN EPI PEN: ◯YES ◯NO

*IS MEDICATION TO BE GIVEN DURING PROGRAM? ◯*YES ◯NO *Please attach medication instructions

SASK HEALTH #: _____ ALLERGIES:_____

OTHER MEDICAL DIAGNOSES:_____

Media Release Authorization

From time to time, we take photos and videos of our programs to use for promotional purposes. By not initializing the box, I acknowledge and agree that Autism Services of Saskatoon, Inc. may use photographs or videos of programming and the participants therein for promotional purposes.

◯ **I DO** permit the use of my child/youth/adult's photos/videos for promotional purposes

◯ **I DO NOT** permit the use of my child/youth/adult's photos/videos for promotional purposes

THIS WAIVER MUST BE SIGNED IN ORDER FOR THIS REGISTRATION APPLICATION TO BE PROCESSED

In the consideration of the acceptance of my application or that of the minor, whose name appears thereon, of whom I am the legal guardian, and the permission to participate in a program sponsored by Autism Services of Saskatoon Inc. I hereby waive and forever discharge the Corporation of Autism Services of Saskatoon Inc., its employees, agents, officers and elected officials from all claims, damages, costs and expenses with respect to injury or damage to my/their person or property, however caused, which may occur as a result of my/their participation in programming in any location where programming is being held (e.g. fields trips, public places, etc.). I also acknowledge and agree to the Program Policies outlined in this document.

SIGNATURE:_____ DATE: _____

Kindergarten Transition Group Registration Form
Page 2

Mail: 209 Fairmont Drive Saskatoon, SK S7M 5B8
Email: registration@autismservices.ca

The Kindergarten Transition Group is designed to meet the needs of our clients diagnosed with ASD who are entering a kindergarten classroom in the fall of 2020. The requirements that need to be met to be accepted into this group are as follows:

1. Your child must be registered to start Kindergarten in the fall of 2020.
2. Your child must be able to attend the full 4 week program.
3. Your child may be asked to attend a screening session, where our staff will evaluate the children in order to properly program for your child.
4. The completed registration, the Financial Assistance application if applying are to be emailed or mailed to our office with payment (Visa, Mastercard or cheque only, no cash accepted) no later than **Wednesday, May 27, 2020.**

The program will be run based on the principles of Applied Behaviour Analysis (ABA). ABA is simply the application of behavioral principles, to everyday situations, that will, over time, increase or decrease targeted behaviors. ABA has been used to help individuals acquire many different skills, such as language skills, self-help skills, and play skills; in addition, these principles can help to decrease maladaptive behaviors such as aggression, self-stimulatory behaviors, and self-injury.

In anticipation of a large number of applications for this program and a limited capacity, all the children who meet the acceptance criteria above may not be accepted into the program.

Questions? Please contact Desirae Boutin at desirae.boutin@autismservices.ca

Program Details:

Dates: August 4—August 28

Days: Monday to Friday

Times: 8:45 AM—12:00 PM *(this will include snack time so please pack a snack every day)*

***Location:** Elim Church, 419 Slimmon Rd, Saskatoon

PAYMENT INFORMATION

TOTAL FEES OWED:_____ ◯ $100 for neurotypical children ◯ $400 for child with ASD

☐ Cash ☐ Cheque #_____ ☐ VISA ☐ MasterCard

Please make cheques payable to *Autism Services of Saskatoon*

☐ I am requesting Financial Assistance to fund programming and/or membership this term.

☐ Bill to Cognitive Disabilities Strategies (CDS)

☐ Bill to Social Services
Worker name: _____

I authorize Autism Services of Saskatoon to charge my:

☐ VISA ☐ MasterCard

Credit Card No:_____

Expiry_____/_____ CVD:_____ (3 digits on back)

Name as appears on card:_____

Signature:_____

PLEASE NOTE: All Visa or Mastercard charges will appear as **BAM* Autism of Saskatoon /Victoria BC** on your credit card statement.

FOR OFFICE USE ONLY

☐ **Registration Complete**
☐ **Confirmation sent to parents**

Invoice/Receipt #: _____

GP Code: _____