The SOAR Experience

For children and teens with solid verbal skills who experience the social communication and social skills challenges seen in Level 1 Autism Spectrum Disorder (formerly referred to as Asperger's Syndrome, HFA and Nonverbal Learning Disabilities) or Social (Pragmatic) Communication Disorder.

Autism Level 1 Services

APPLICANT APPLICATION AND REGISTRATION FORM (2017)

Completion of this form is necessary for admittance to The SOAR Experience.
In addition, prospective applicants who are new to West Bergen may be interviewed by senior staff to determine if the child will benefit from the summer program.

APPLICATION DEADLINE: MAY 12, 2017
If available, please attach an individual picture of the potential participant

1. Applicant Information

The Applicant's Name: _____ Date of Birth: _____

Biological sex: ( )Female ( )Male ( )Intersex/DSD

Gender Identity: ( ) Man ( ) Woman ( ) Trans ( ) Transgender ( ) Transsexual ( )Genderqueer
(OPTIONAL)

T-shirt size (circle one): Youth sizes: S M L XL

Adult sizes: S M L XL XXL

Home Address:

_____

Street Apt# City State Zip Code

Primary Phone Number: _____

Language(s) Spoken at home: _____ Does a parent speak English? Yes ( ) No ( )

Parent's marital status: _____

Grade: _____ School: _____

Please check any of the following that apply:

___ Mainstreamed ___ Mainstreamed with Supports - List Supports:

___Self - Contained Classroom ___ Out of District Placement ___ Home Schooled

Has any third party, such as an agency or school district agreed to fund the applicant's participation in SOAR?

Yes ( ) No ( ) If so, third party name:_____

Contact person:_____ Contact information: _____

The applicant is:
( ) Past SOAR Experience Participant ( ) Current West Bergen Client (Therapist: _____)
( ) Former West Bergen Client ( ) Has never been a client at West Bergen

How did you find out about our program?
_____

_____

2. Family Information:

Parent-Guardian #1

_____
Name

_____
Relationship to the applicant

_____
Address
(____)_____
Home Phone
(____)_____
Work Phone
(____)_____
Cell Phone

(____)_____
E-Mail (Please print clearly)
_____

Parent-Guardian #2

_____
Name

_____
Relationship to the applicant

_____
Address
(_____)_____
Home Phone
(_____)_____
Work Phone
(_____)_____
Cell Phone

(_____)_____
E-Mail (Please print clearly)
_____

Current parental status:
( ) Married ( ) Separated ( ) Divorced ( ) Never married
( ) Both parents living in same home as applicant ( ) Parents living apart in separate homes

Please be sure to inform us if a visitation schedule might affect your child's routine while at the SOAR Experience:

Household Members: Please list every member of the household:

NAME	DATE OF BIRTH	RELATIONSHIP

***3. Emergency Contacts*:**
Please identify **at least 2 and up to 4** people **(other than parent/guardian listed on previous page)** who may be called between 9 AM and 3 PM when you are not available.

Name:	**Telephone Numbers:**	**Relationship to child:**
1.		
2.		
3.		
4.		

4. Trip Permission
I give my child permission to take walking trips and bus trips with the West Bergen SOAR Staff.
( ) Yes ( ) No

5. Dismissal Procedure
Parents are encouraged to pick up their child, if walking is not an option.

I give my child, who is 12 years of age or older, permission to walk home alone at dismissal time – 3:00 PM.
( ) Yes ( ) No

People permitted to pick up my child:

Name	Relationship to Child	Day- Time Phone	Cell Phone

If you do not want your child picked up by a specific adult, please answer all of the following questions (A-C).

A. My child **MAY NOT** be picked up by the following individual because there is an active order of protection
Name_____ Docket #_____Expiration Date _____

B. My child is aware of this order and will report this adult to a West Bergen Staff member
( ) Yes ( ) No

C. I realize that there is no easy way of monitoring who picks up my child after the program. If I think this may be a problem, I will make an appointment with the SOAR Director at 201-934-1160 to set up a special procedure for dismissal.

( ) Yes, I think there may be a problem ( ) No, I do not anticipate any problems

6. About Your Child (please use separate page if necessary)

Child's strengths:

Child's Challenges:

Child's preferred coping strategies/tips for when your child is struggling/what distracts them:

Does your child/teen use any assistive technology devices to optimize his/her functioning at school, home or socially/within the community? Has your child benefitted from such devices in the past? Will your child be bringing any such devices to the SOAR Experience? If yes to any of the above, please identify devices, typical amount and purpose of use, etc:

Child's social communication ability (i.e. how often does your child appropriately and successfully initiate, maintain and end conversations with others, how does your child do communicating one on one versus in a group setting, etc.) :

Child's play activity and peer relationships (what does s/he like to play with, special interests, talents, passions, how s/he does with peers, types of relationships in his/her life, etc.):

Identify all sensory, motor, behavioral, nutritional or additional issues that would help us to work more effectively in making this a successful experience for your child:

Are there any fears, anxiety, sensory issues, coordination issues, etc that would affect your child's ability to handle certain activities or trips (i.e. fear of the dark or clowns or bugs, unable to use scissors independently, poor swimmer, etc.)?

Is there any family or cultural factors that you think would be important for the SOAR Experience staff to be aware of while working with your child?

Has your child had any incidents of aggression and/or self-injurious behavior at school, home or in the community during the last 12 months? Please describe.

Have there been any hospitalizations during the child's life for social-emotional-behavioral issues? This includes PESP visits, Emergency Room visits, emergency risk assessments of visits from Children's Mobile Crisis. If yes, please state when and describe briefly.

Please note any additional information you think might help the SOAR Experience staff work more effectively with your child:

7. Photo/Video/Interview Consent

Please note: Sometimes children want to be in photos or videos when parents have not given permission. Under those circumstances, children feel excluded when asked to move out of the camera lens view. We may have activities that involve photos and video.

*I understand that The SOAR Experience features special events both in the facility and away from the facility where photos or videos may be taken. In addition, part of the social skills programming requires video taping applicants practicing their skills and then reviewing those tapes. Note: **The use of the term "non-identifying" in the selections below is being used to indicate that your name would not be used or attached to the photograph** Please indicate your preference with regard to photos and videos by checking the choices below (Please initial all that apply):

_____ I agree to allow my child to be photographed for the child to bring home
_____ I agree to allow my child to be photographed for use within the groups at the program
_____ I agree to allow my child to be in a video for use within the groups at the program
_____ I agree to allow my child to be in a non-identifying photograph that may be used in a West Bergen presentation aimed at increasing awareness and educating others
_____ I agree to allow my child to be in a non-identifying video that may be used in a West Bergen presentation aimed at increasing awareness and educating others
_____ I agree to allow my child to be in a non-identifying photograph that may be used in a West Bergen publication
_____ I agree to allow my child to be in a non-identifying video that may be used in a West Bergen fund-raising video

The undersigned, on his or her own behalf and on behalf of the child, as well as on behalf of all of the Undersigned and Child's heirs, successors and/or assigns, does hereby release WBMHC and its and their heirs, successors, and/or assigns from any and all claims, demand, and liability of whatever kind, including but not limited to payment of any compensation, for misappropriation or misuse of any publicity, trademark, copyright, or other rights of the Child and/or Undersigned and their heirs, successors and/or assigns, arising out of photographs/video of you or your child.

_____ _____

****Parent/Guardian*** ***Date***

8. Services and Service Provider Information

Type of therapy/services applicant is receiving: _____	Type of therapy/services applicant is receiving: _____
Reason For Service: _____	Reason For Service:_____
Provider Name:_____	Provider Name:_____
How long in this service: _____	How long in this service: _____
Address:_____	Address:_____
City:_____State:_____Zip:_____	City:_____State:_____Zip:_____
Phone:_____Fax:_____	Phone:_____Fax:_____

9. Other Provider Information (if applicable)

Case manager:_____	Therapist:_____
Address:_____	Address:_____
Reason For Service: _____	Reason For Service: _____
City:_____ST:_____Zip:_____	City:_____ST:_____Zip:_____
Phone:_____	Phone:_____
Fax:_____	Fax:_____

10. Diagnostic and Classification Information:

Psychiatric Diagnosis:_____

Educational Classification: _____

★**Copies of most recent diagnosis and evaluations, including IEP (if classified) MUST accompany this application**

★**Please check off all of the following that have been included with the application:**

☐ Diagnostic evaluation completed by_____
☐ Evaluations attached – Identify_____
☐ **IEP and ALL EVALUATIONS/REPORTS used to *generate* the IEP attached**

11. Emergency Medical Care

Applicant's Name: _____ Date of Birth: _____

1. If my child requires emergency medical care and I cannot be reached, I give my consent to The SOAR Experience and West Bergen Mental Healthcare to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child received. I understand that every effort will be made to contact me before and after medical care is provided.

*Parent/Guardian
Signature:_____Date:_____

2. Health/Insurance Information:
Applicant's Primary Doctor: _____(Fill in all information on this physician in 1st box below)

Insurance Company: _____ Policy Holder's Name: _____

Insurance ID Number: _____ Religious Preference: _____

12. Current Medical providers:

Applicant's Primary Physician:	Applicant's Other Doctor:
_____	_____
Type of Physician: _____	Type of Physician: _____
Address:_____	Address:_____
City:_____State:_____Zip:_____	City:_____State:_____Zip:_____
Phone:_____Fax:_____	Phone:_____Fax:_____

13. Medical Health Information:

If accepted, please attach a letter to this application from applicant's primary physician stating the applicant's general health, any medical conditions, medications prescribed and vaccination status. For those taking medication, you will be required to produce prescription documentation for medication distribution onsite and medication must come to the site in the original container. All children with allergies requiring a prescription for an Epinephrine Injection pen (EpiPen) must provide an EpiPen to be left at the SOAR Experience for the duration of the child's attendance at the program.

List all Present Medical Conditions and related treatments (including any information regarding vision, hearing or mobility): _____

_____

_____

Medication(s) and Dosages(s):_____

_____

Past Medical History: _____

_____

Vaccination History:
( ) My child received all vaccinations to date.
( ) My child received all vaccinations except the following: _____

_____

( ) My child has not received any vaccinations to date.

Food Allergies and Dietetic needs:

( ) The applicant has no known food allergies and/or other restrictions.

( ) The applicant has the following food allergies and/or food restrictions: _____

_____

( ) I give permission for my child to eat meals or snacks provided by the program

( ) I do not give permission for my child to eat meals or snacks provided by the program. My child will bring his/her own snack and lunch.

( ) My child has the following additional dietary needs: _____

_____

( ) My child knows not to eat the foods related to his allergies and/or dietary regiment and will ask about the ingredients of a particular food if he/she is unsure of the contents.
Foods your child needs to avoid:

Other Allergies: _____

Sensitivities (i.e. sun, sun block, bug repellent, etc.) _____

_____ Date: _____

*****Parent/Guardian Signature:

14. Release and Authorization

I give permission to SOAR program staff and West Bergen Mental Healthcare or its agents to obtain education/psychological/medical/service information from my child's school, other educational sources, doctors, therapists, counselors, or other professionals if necessary in order to evaluate applicant's acceptance and placement. This authorization shall be effective until revoked by me in writing and delivered to the West Bergen Mental Healthcare, The SOAR Experience Director or the Director of Asperger's Related Services.

*****Parent/Guardian Signature:_____Date:_____

15. Payment Information

A minimum $500 deposit is required at time of application for all applicants. Applications must be completed in full and returned with all requested records. An interview may also be required. The application, record review and interview assists in predicting whether this summer program is a good fit for your child. Any deposit/payment will be returned in full should applicant not be accepted. **Full payment of balance due no later than June 16, 2017**.

Check which session your child is applying for:

3 Week Session: □ July 10 – July 28 ($2,200 Tuition) □ July 31 –Aug 18 ($2,200 Tuition)

6 Week Session: □ July 10 – August 19 ($4,200 Tuition)

Amount Enclosed Reflects: Check all below that apply

_____ $500 Deposit

_____ $2,200 or 4,200 Full payment (circle one)

_____ Additional payment beyond the deposit in the amount of $ _____ toward balance

Total to be paid today: _____ by: □ Check □ Cash

****Please note: If you would like to make your payment via credit card, it must be done in person or over the phone. Please call Amy Whritenour at 201-934-1160 should you wish to make arrangements to pay over the phone. West Bergen accepts the following credit cards - Mastercard, Visa, American Express, Discover***

Please Note: Your deposit will NOT be returned if you withdraw from the program after being accepted. You will NOT be reimbursed for missed days or if you decide to withdraw your child at any point during the program.

16. Permission to attend:

I give my child permission to participate in The SOAR Experience.

All of the information I provided is true. I understand that all consent information I provided will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this summer program.

*_____ _____

Parent/Guardian signature ***Date***

Please Return Applicant Application and Registration Form to and For Further Information Contact:
The SOAR Experience, West Bergen Mental Healthcare
One Cherry Lane, Ramsey, NJ 07446 201-934-1160 www.westbergen.org

Please Note:
The SOAR Experience will take place at West Bergen's Ramsey Location