Kaleidoscope Applied Behavior Analysis

Application for Admission

Child's Name: _____
(First) (Middle) (Last)
Address: _____
Date of birth: _____
Clinical Diagnosis: _____

Other conditions that apply:
☐ **Seizure disorder** ☐ **Food Allergies** ☐**Asthma**
☐ **Other- please specify _____**

Father's name/ Legal Guardian _____
Address: _____
Home Phone: _____
Cell phone: _____
Work phone: _____
E-mail: _____
Employer : _____
Occupation: _____

Mother's name/Legal Guardian _____
Address: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
E-mail: _____
Employer: _____
Occupation: _____

Parent's Marital Status: ☐**Married** ☐ **Separated** ☐ **Divorced** ☐ **Single**

Child resides with: ☐ **Mom** ☐**Dad** ☐ **_____**

Child's Siblings:
Name: _____ Age: _____ M or F
Name: _____ Age: _____ M or F
Name: _____ Age: _____ M or F
Name: _____ Age: _____ M or F
Name: _____ Age: _____ M or F

How did you find out about us?
__ parent referral __website __ physician __ other_____

Pediatrician: _____
Phone: _____

Other treating physician: _____
Specialization: _____
Phone: _____

Number of hours you wish your child to receive weekly:
20 hours __ 25 hours __ 30 hours __ 35 hours __ Other ____

Are you interested in the early learner program or advanced learner program:
__Early learner __Advanced learner- ABLLS 75% completed

Did your child previously attend public or private school or daycare?
School Name: _____
Program type:_____

Has your child had previous ABA therapy?
Consultant or center name: _____
Phone: _____
Number of hours per week: _____
Duration: _____

Is your child able to go for weekly YMCA activities?	**☐ Yes**	**☐ No**
Does your child babble or make speech sounds?	**☐ Yes**	**☐ No**
Does your child point to communicate?	**☐ Yes**	**☐ No**
Does your child injure himself or others?	**☐ Yes**	**☐ No**
Does your child use their free time appropriately?	**☐ Yes**	**☐No**
Does your child have a good appetite?	**☐ Yes**	**☐ No**
Does your child have an unusual level of activity?	**☐ Yes**	**☐ No**
Does your child dart or run from adults?	**☐ Yes**	**☐ No**
Does your child speak using words or sentences?	**☐ Yes**	**☐ No**

What are some of the initial goals you have for your child?

1. _____

2. _____

3. _____

4. _____

5. _____

What level of commitment are your willing to make at home to help realize these goals?_____
_____

Please know that the child who will benefit most from our intensive behavioral therapy program and maintain new skills is the child whose family supports and generalizes behavioral teaching at home. Applied behavior analysis must be utilized across environments and persons for maximum effectiveness.

A good reference book for parents is Behavioral Intervention for Young Children with Autism. A copy may be purchased from different roads to learning (difflearn.com).

Parents are expected to be familiar with their child's daily data sheet in order to better teach their child and generalize treatment gains at home. General knowledge of the Assessment of Basic and Learning Skills (Sundberg and Partington) will be helpful in keeping up with your child's program. You may take your child's copy home to study if you desire.

Thank you for giving us the opportunity to help you reclaim your child!

Parent/Legal Guardian: _____
Parent/ Legal Guardian: _____
Date:_____

Please send this application and $350.00 non-refundable application fee, which is used for the purchase of language cards:

Kaleidoscope Applied Behavior Analysis
153 Norcross Street
Roswell, Georgia 30075

We will notify you of your child's enrollment status promptly.

When your child attends Kaleidoscope a fully refundable enrollment deposit is required upon the start of your child's treatment. This deposit is refundable with 30 days notice of exit date.

Kaleidoscope is a not for profit organization and does not discriminate on the basis of race, religion, age, gender, disability, national origin or marital status in its practices or programs.