Youth Social Group Application

Autism Delaware is pleased to announce we are now accepting applications for our 2018-2019 Social Groups!

Which Youth Social Group are you applying for:

- ☐ BRAVE Girls Social Group (girls ages 10-19), Newark Office of Autism Delaware, $60
- ☐ Boy's Social Group (boys ages 13-18), Newark Office of Autism Delaware. $60
- ☐ Leaps and Bounds (ages 5-8), First State Martial Arts, Dover, DE, $60

Purpose of the Group: The Autism Delaware Social Groups are designed to provide a traditional social group experience with necessary supports from staff who understand the special needs of youth with ASD. Our goal is to help each child have a fun and successful recreation/social experience building new peer relationships, exploring new activities, and making gains in independence. Group will also provide the opportunity for respite for families!

The social program is structured to be filled with new adventures within a repeating schedule. Activities may include: movies, restaurants, sporting events (maybe attending, maybe an actual sport), AD's Amazing Race, maybe occasional travel, and more! Throughout each activity, emphasis is put on communication, social skills, and building self-esteem. We use a "Challenge by Choice" approach throughout social activities, meaning that we encourage participants to try new things, but never force them into an activity. Emotional and physical safety is always our priority.

This is a drop off program and is considered Respite by DDDS. You MUST notify DDDS if you intend to utilize your respite find for this program. Contact the DDDS Respite Unit and/or Community Navigator to determine available funds for this program. In addition, a limited number of scholarships are available. Please contact Annalisa at annalisa.ekbladh@delautism.org or 302-224-6020 for more information and an application.

Please feel free to ask questions you may have about a social group. Contact: Resource Coordinator Heidi Mizell at 302-224-6020 or by email at Heidi.Mizell@delautism.org.

2018-19 Autism Delaware Social Group Application

Name of Participant: _____ Birth date: ____/____/____

Age: _____ Grade for 2018-2019 School Year: _____

Address: _____

City: _____ State: _____ Zip: _____

Participants's Diagnosis: ___ Autism ___ Asperger's ___PDD-NOS Other: _____

Please bring your completed application to the next session

GROUP INFORMATION

The following Social Group policies will apply:

- Please keep in mind that part of group may involve being outdoors.
- Each potential participant is considered on a case by case basis. We cannot provide one on one staffing for any one participant.
- You know your child is ready for group if they have functional communication and have an interest in being social. They should have an interest in participating in a group and group activities, and do not have frequent, intense aggressive behaviors.
- Participants may occasionally dine together. It is important to inform staff of any allergies/sensitivities your child may have; and to teach your child how to self-advocate should they have any allergies/food sensitivities.
- We will have plenty of sunscreen available during outdoor activities and will apply to every participant prior to going outside, if necessary. If your child uses a special sunscreen, we will ask you to provide it. If you have specific instructions for sunscreen for your child, please describe them in the application.
- Autism Delaware is not responsible for lost, broken, or stolen items. It is suggested to not bring electronics to events.
- We do not provide transportation to or from events. Families are responsible for providing their child's transportation. If you have transportation needs, we may be able to help connect families to set up car pools.

Please let us know if you have any questions. We look forward to working with your child.

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CONTACT INFORMATION

Parent/Guardian #1 Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
(Please circle the best phone to reach you on while your child is at group)

Email: _____

Address: _____ City: _____

State: _____ Zip: _____

Works at: _____ City: _____

****

Parent/Guardian #2 Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
(Please circle the best phone to reach you on while your child is at group)

Email: _____

Address: _____ City: _____

State: _____ Zip: _____

Works at: _____ City: _____

****

If the above Parent/Guardians are not available in an emergency, notify:

Emergency Contact Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email_____

Address _____

City_____ State_____ Zip _____

Works at: _____ City: _____

EDUCATIONAL

Name of participant's school: _____ State: _____

Is the participant in a special autism educational program? ___Yes ___ No

Does this participant have an IEP? ___ No ___ Yes - If so, what is the participant's educational classification? _____

Does your child require 1:1 support in the following at any time? ___No ___ Yes: If yes, why?

Child's Name: _____

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HEALTH INSURANCE INFORMATION

Is the participant covered by family medical insurance? ___Yes ___No

Health Insurance Company: _____

Group #: _____ Member #: _____

***A photocopy of the front and back of camp participant health insurance card must be attached to this form. ***

PHYSICIAN INFORMATION

Name of Participant's Physician: _____ Phone: _____

Address: _____

Name of Participant's Dentist: _____ Phone: _____

Address: _____

MEDICATIONS

Please list ALL medications, including over-the-counter or nonprescription:
____This participant takes NO medications on a routine basis.

____This participant takes medications as follows:

Med #1_____ Dosage: _____ Reason: _____

Specific times taken each day_____ Prescribing Physician: _____

Med #2_____ Dosage: _____ Reason: _____

Specific times taken each day_____ Prescribing Physician: _____

(Attach additional pages for more medications.)

ALLERGIES (List all known. Also describe reaction and management of the reaction.)

___ NO ALLERGIES

Medication allergies (list):_____

Food allergies (list): _____

Other allergies (list): — include insect stings, animal dander, etc.: _____

RESTRICTIONS (attach additional pages if necessary)

Participant does not eat: __Red meat __Pork __Dairy products __Poultry __Seafood __Eggs ___N/A-no restrictions

Other (describe): _____

___Due to special diet, we will send in snacks/edible rein forcers for our child

Explain any restrictions to activity _____

Can we apply our sunscreen to your child during outside activities?
___ Yes ___ No, the family will provide sunscreen for our child to use during camp

Child's Name: _____

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GENERAL MEDICAL HISTORY

Is your child currently healthy? _____ Current medical conditions: _____

	Has/does your child:	**YES**	**NO**
1	Ever had/have seizures?		
2	Any recent injury, illness or infectious disease?		
3	Chronic or recurring illness/condition?		
4	Wear glasses, contacts or protective eye wear?		
5	Persistent medical history/event in the past month?		
6	Frequent headaches?		
7	Ever had a head injury?		
8	Ever had frequent ear infections?		
9	Ever been knocked unconscious?		
10	Ever had surgery?		
11	Ever been hospitalized?		
12	Ever passed out during or after exercise		
13	Ever been dizzy during or after exercise?		
14	Ever had chest pain during or after exercise?		
15	Ever had high blood pressure?		
16	Ever been diagnosed with a heart murmur?		
17	Ever had back problems?		
18	Ever had problems with joints (e.g., knees, ankles)?		
19	Any skin problems (e.g., itching, rash, acne)?		
20	Have diabetes?		
21	Have asthma?		

Explain any "yes" answers, noting the number of the question first: _____

_____

_____

_____

Has your child had the following : (Circle to indicate "Yes")

Measles Chicken pox German measles Mumps Hepatitis A Hepatitis B Hepatitis C TB

Mantoux test (Date of last test_____) Result: ___Positive ___Negative

Child's Name: _____

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COMMUNICATION

How does your child communicate to ask for things, ask for help, indicate yes/no, etc.?

MODE	PLEASE LIST EXAMPLES
❑ SPEAKS CLEARLY	
❑ SPEAKS but MAY BE DIFFICULT TO UNDERSTAND	
❑ PECS / PICTURES	
❑ SIGN LANGUAGE	
❑ COMMUNCIATION BOARD OR DEVICE	
❑ GESTURES	
❑ OTHER:	

Language spoken/understood: _____

Vision: ___Normal ___ Mild/Moderate Loss ___ Severe/Total Loss ____ Wears corrective lenses

Hearing: ___ Normal ___ Mild/Moderate Loss ___ Severe/Total Loss ____ Wears hearing aides

Mobility

___Walks independently ___ Walks with assistance: _____ ___ Uses wheelchair : ___manual ___ power

SELF-CARE

Skill	Independent- No assistance needed	With Prompting Only	With Supervision	With Assistance	Comments
Using Toilet	❑	❑	❑	❑	
Undress	❑	❑	❑	❑	
Get dressed	❑	❑	❑	❑	
Wash hands	❑	❑	❑	❑	
Eat lunch	❑	❑	❑	❑	

____ My child needs prompting to use the bathroom ____ My child will request to use the bathroom by: _____

Is this participant on a toileting schedule__No __Yes: please provide the schedule: _____

SWIM EXPERIENCE

Familiarity with pool/beach:	❑ None- has not been in a pool or ocean/ beach	❑ Minimal experience with water at pool/beach	❑ Has spent some time at either pool or beach	❑ Has spent a lot of time in pool/beach, very comfortable
Level of swimming skill:	❑ Cannot swim at all, not comfortable in water	❑ Cannot swim but is comfortable in pool/beach. Likes the water	❑ Can swim a little. Should not go in deep end.	❑ Good swimmer. Can support self in water

Child's Name: _____

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Is there anything else you feel is important for us to know about the participant's **medical history, health, communication, or self-care skills**? **Please note: behavior will be addressed below.**

_____

_____

_____

BEHAVIOR

Check any item(s) identifying behavior exhibited by this child:

___ Self-injury: ___Bites ___ Hits/kicks ___ Pulls hair ___ Picks self Other: _____

___ Aggression towards others: ___ Bites ___ Hits/kicks ___ Pulls hair Other: _____

Date of most recent aggressive behavior: _____

___ Wanders/runs from group
___ Cries or becomes upset easily
___ Exaggerates pain/illness
___ Difficulty taking direction
___ Seeks steady attention
___ Excessive cursing/vulgarity
___ Temper tantrums
___ Elevated emotional needs
___ Overly dependent on others
___ Seeks steady entertainment
___ Screams
___ Overly fearful
___ Teases others
___ Elevated sexual interest
___ Other: _____

List details to help explain behavior areas checked above and any specific methods to resolve behavior difficulties:

_____

_____

_____

Does the participant have any other behaviors of which the staff needs to be aware?

What is the behavior?	Why does he/she do it?	How do we help/respond?	How can we prevent it?

Does this participant currently have a behavior support plan?

___Yes ___No

If Yes, PLEASE SEND A COPY WITH THIS APPLICATION for informational purposes only.

Does your child understand dangerous situations? (i.e. running in parking lot, entering water without supervision?)

___ Yes ___ No _____

Triggers: What makes your child upset, angry, anxious, and/or overwhelmed?

___ Being touched
___ Loud Noises
___ Yelling
___ Having to rush/hurry
___ Encroachment of personal space
___ Bright or flashing lights
___ Specific people or peers
___ Introduction to new foods
___ New places or schedules
___ Crowds
___ Heat/hot outside
___ Not being able to finish something before moving on

___ Other: _____

Child's Name: _____

Autism DELAWARE

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BEHAVIOR CONTINUED

List any circumstances that will increase the likelihood of negative behavior (i.e. loud noises, animals, the dark, etc.). List situation and behavior displayed.

_____

_____

Warning Signs: What are some warning signs that your child exhibits when frustrated or in distress?

___ Pacing
___ Crying
___ Yelling
___ Sweating
___ Clenching teeth
___ Face turns red
___ Not talking
___ Swearing
___ Running
___ Clenching fists
___ Breathing hard/fast
___ Excessive or fast pace talking
___ Being rude
___ Not eating
___ Throwing objects
___ Verbal Comments: _____

___ Other: _____

Explain: _____

Calming Strategies: What helps your child calm down?

___ Taking a walk
___ Listening to music
___ Wrapping in a blanket
___ Stuffed animals
___ Getting a drink of water
___ Reading a book
___ Dark room (dim the lights)
___ Calling family member
___ Taking a break/removal from environment until calm
___ Talking to staff
___ Writing/drawing
___ Other: _____

Explain: _____

_____

_____

Are there key actions, words, or phrases used to stop behavior and redirect? ___ No ___ Yes - If yes, please explain:

_____

Please list any reinforcers your child likes, or things he or she will work for. **Keep in mind electronics are discouraged at social group**

_____

_____

Although we do not provide direct instruction or implement specific behavior plans at social group, please share any specific things he/she is currently working on that you would like us to encourage if possible. (Ex: talking to peers, asking for a break when overwhelmed, etc)

_____

_____

Child's Name: _____