



The Faison School for Autism  
Affiliated with Virginia Commonwealth University  
After-School Program Application

(please use reverse if more room is needed)

I. General Information

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

School District: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Primary Caretaker(s): \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Home Address: \_\_\_\_\_

Work Phone #1: \_\_\_\_\_ Home Phone #1: \_\_\_\_\_

Work Phone #2: \_\_\_\_\_ Home Phone #2: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Fax: \_\_\_\_\_

Pager/Cell Phone: \_\_\_\_\_

Will your child require a snack while attending the After-School Program? \_\_\_\_\_

If so, what kind of snack? \_\_\_\_\_

II. Reason for seeking placement at The Faison School After-School Program

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. Describe child's current school placement:

1. Name of Program: \_\_\_\_\_

Location: \_\_\_\_\_

Dates Attended: \_\_\_\_\_

Type of services received: \_\_\_\_\_

Hours of services received: \_\_\_\_\_

Adult to Child Ratio \_\_\_\_\_

IV. List other interventions currently being used (if any) such as medical, related services, home therapies

1. Type of Intervention: \_\_\_\_\_

Starting and end dates: \_\_\_\_\_

Purpose of Intervention: \_\_\_\_\_

Hours per Week: \_\_\_\_\_

Comment \_\_\_\_\_

2. Type of Intervention: \_\_\_\_\_

Starting and end dates: \_\_\_\_\_

Purpose of Intervention: \_\_\_\_\_

Hours per Week: \_\_\_\_\_

Comment \_\_\_\_\_

V. List of Professionals currently involved in child's treatment that we may contact

1. Name and Title: \_\_\_\_\_

Area of Specialty: \_\_\_\_\_

Agency/Office: \_\_\_\_\_

2. Name and Title: \_\_\_\_\_

Area of Specialty: \_\_\_\_\_

Agency/Office: \_\_\_\_\_

VI. Medications Taken

List allergies and reactions/protocols: \_\_\_\_\_

\_\_\_\_\_

1. Name of Medication: \_\_\_\_\_

Name & Title of Prescribing Physician: \_\_\_\_\_  
(e.g. Dr. Jones, Psychiatrist)

Dosage: \_\_\_\_\_

Date current dosage began: \_\_\_\_\_

Reason for medication: \_\_\_\_\_  
(e.g. hyperactivity, enuresis)

Will this medication need to be administered during the After-School program? \_\_\_\_\_

**2. Name of Medication:** \_\_\_\_\_

Name & Title of Prescribing Physician: \_\_\_\_\_  
(e.g. Dr. Jones, Psychiatrist)

Dosage: \_\_\_\_\_

Date current dosage began: \_\_\_\_\_

Reason for medication: \_\_\_\_\_  
(e.g. hyperactivity, enuresis)

Will this medication need to be administered during the After-School program? \_\_\_\_\_

VIII. Please use the following space to include any additional information that you feel to be relevant and important.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IX. Please include copies with the following information from the last 12 months (if applicable). Please check off those that are being included.

- 1. IEP, IFSP, or other formalized educational plan
- 2. Physical and/or medical evaluations
- 3. Psychological or psychiatric evaluations (with diagnosis)
- 4. Adaptive behavior evaluations (may be part of a social history)
- 5. Related services evaluations (occupational/physical therapy, speech/language, etc.)
- 6. Immunization records (since birth)
- 7. Physical Examination record