SUCCESS ON THE SPECTRUM

ADMISSIONS FORM

Dear Parent,

Thank you for selecting Success On The Spectrum to meet the needs of your child. We appreciate your trust and look forward to getting to know you and your family better. If you have questions or concerns about anything, please do not hesitate to contact us.

We realize that getting a diagnosis of an Autism Spectrum Disorder (ASD) is a very stressful event for parents. Success On The Spectrum will provide treatment to your child and also give support to you. You are your child's strongest advocate and there is much you can do to help your child to live a happy and independent life! Success On The Spectrum strongly encourages parent involvement. We will train you to use the same ABA methods so that your child receives consistent, effective instruction. We also ask that you stay in constant contact with us. We want to know about every problem behavior so that we can help you eliminate it!

The first step to getting treatment is to email or fax us the following items:

DOCUMENTATION	
Send us a copy of:	❑ Front and Back of Insurance Card ❑ Scored, Autism Diagnosis Report from a doctor (not a school) ❑ Recent Note from doctor saying that child is recommended to have ABA (within last year) ❑ Previous ABA Therapy Records ❑ Previous Speech Therapy Records ❑ Previous Occupational Therapy Records ❑ School IEP records

After completing the above steps, Success On The Spectrum will then contact your insurance company and verify your benefits. Once approved, our experienced Board Certified Behavior Analyst (BCBA) will set up an appointment for an initial behavior assessment with your child.

Initial assessments are done at our center and usually last about 4-6 hours. Our BCBA will use toys and games to identify your child's skill levels. When finished, the BCBA will write a report with all of the findings and share them with you. Based on the data collected, the BCBA will create a detailed treatment plan for your child.

After 6 months of receiving ABA therapy, your child's skill levels will be evaluated again. The results will be compared to previous test's results to be sure that progress is being made. The BCBA will always discuss the results with you and make changes if needed. You will also be given access to your child's progress records on our secure online portal. Some children learn faster than others, so please be patient with them.

Be assured, Applied Behavior Analysis (ABA) has been scientifically proven to work. We want every child to reach their fullest potential! When they succeed, we succeed!!!

Please send this application to your
preferred Success On The Spectrum location.

Thank you,
The Success On The Spectrum Team

SUCCESS ON THE SPECTRUM

ADMISSIONS FORM

CHILD'S INFO	
Today's Date:	
Child's Name:	❑male ❑female
Child's Date of Birth:	

PRIMARY HEALTH INSURANCE INFO	
Insurance Company:	
Member ID:	
Group#	
Policyholder's Name: (Usually a parent)	❑male ❑female
Policyholder's Date of Birth:	
Policyholder's Social Security Number:	
Policyholder's Address:	

SECONDARY HEALTH INSURANCE INFO	
Insurance Company:	
Member ID:	
Group#	
Policyholder's Name: (Usually a parent)	❑male ❑female
Policyholder's Date of Birth:	
Policyholder's Social Security Number:	
Policyholder's Address:	

PARENT INFO			
Custodial Parent: (Circle one)	Both: Parents are married	Child lives with Dad	Child lives with Mom
Custodial Parent's Name:			
Custodial Parent's Email:			
Custodial Parent's Phone:	Mobile:	Home:	Work:
Parent #2 Name:			
Parent #2 Email:			
Parent #2 Phone:	Mobile :	Home:	Work:
Emergency Contact (other than parents):			
Emergency Number:			

DESIRED SERVICES	
ABA Therapy:	❑ In-Center ABA Full-time or Part-time options available ❑ In-Home ABA Only offered Monday - Thursday 4:30pm- 6:30pm Must live within 10 miles of a center Must have no aggressive behaviors Additional Mileage Fees apply ❑ In-School Shadowing ABA must have school approval Additional Mileage Fees apply
Speech Therapy:	❑
Occupational Therapy:	❑
Social Skills Group Classes:	❑ Primary Social Group (Kindergarten - 2nd grade) ❑ Elementary Social Group (3rd - 4th grade) ❑ Intermediate Social Group (5th - 6th grade) ❑ Tween Social Group (7th - 8th grade)
Before/After Care:	❑ Early Drop Off (as early as 7:00am) ❑ Late Pick Up (as late as 6:00pm)

SUCCESS ON THE SPECTRUM

HIPAA AGREEMENT FORM

PRIVACY POLICY

SOS is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI).
SOS will not use or disclose your PHI for marketing or fundraising purposes; SOS will not sell your PHI to anyone for any reason.
SOS will only use your PHI in an appropriate manner for treatment.
SOS will only disclose PHI to the child's legal guardian. A legal guardian must give written authorization to allow us to share PHI with others.

RIGHTS

1. You have the right to access your PHI at anytime. SOS does not charge fees to access your records.
2. You have the right to know who had access to your PHI within the last 6 years.
3. You have the right to limit our access to your health records.
4. You have the right to revoke access to your PHI that was previously given to us at any time.
5. SOS will notify you immediately if we become aware that an unauthorized person accessed your PHI.
6. You have the right to complain to the US Department of Health and Human Services if you feel that your rights have been violated.

EXCEPTIONS

1. SOS may disclose your PHI without your written permission when required By Law. When disclosure is (a) required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement; (b) compelled by a party to a proceeding before a court, arbitration panel or an administrative agency pursuant to its lawful authority; (c) required by a search warrant lawfully issued to a governmental law enforcement agency; or (d) compelled by the patient or the patient's representative pursuant to state or federal statutes or regulations, such as the Privacy Rule that requires this Notice.
2. SOS may disclose your PHI without your written permission for health oversight activities authorized by law including, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. SOS may disclose your PHI without your written permission to avoid harm. When disclosure: (a) to law enforcement personnel or persons may be able to prevent or mitigate a serious threat to the health or safety of a person or the public; (b) is compelled or permitted by the fact that the Client is in such mental or emotional condition as to be dangerous to him or herself or the person or property of others, and if AST determines that disclosure is necessary to prevent the threatened danger; (c) is mandated by state child abuse and neglect reporting laws (for example, if we have a reasonable suspicion of child abuse or neglect); (d) is mandated by state elder/dependent abuse reporting law (for example, if we have a reasonable suspicion of elder abuse or dependent adult abuse); and (e) if disclosure is compelled or permitted by the fact that you or your child tells us of a serious/imminent threat of physical violence against a reasonably identifiable victim or victims.
4. SOS may disclose your PHI without your written permission to company attorneys, accountants, consultants, and others to make sure that SOS is in compliance with applicable laws.
5. SOS may disclose your PHI without your written permission to your health insurance company to obtain benefit information, payment for treatment and services provided.
6. SOS may disclose your PHI without your written permission in the event of an emergency situation (such as a hospital visit).

SURVEILLANCE SYSTEM

1. Inside our center, there are video cameras that record video/audio and display the live feed in the parent viewing room.
2. All recordings are kept on a password protected internal DVR system and not broadcast over the internet. Recordings are kept for a limited time and then written over.
3. SOS is the owner of all video/audio. No one (not even the parents) is allowed to possess pictures/video/audio from our surveillance footage (unless subpoenaed by a court).
4. This video/audio may be used by SOS for parent training or staff training.

When clients/parents/visitors come into the center (or observe therapy outside of the center), it is possible that they see your child or overhear their ongoing treatment. By signing this agreement, you give permission to SOS to capture images/audio of your child and display them in the parent viewing room.

_____
initials

I have read and understood Success On The Spectrum's Privacy Policy.

Print Name	Date
Signature	

SUCCESS ON THE SPECTRUM

PAYMENT AGREEMENT

Print Child's Name:	

AUTHORIZATION:

- I authorize Success On The Spectrum to make medical reimbursement claims with my health insurance policy for services provided to my child.
- Any pre-authorization obtained by Success On The Spectrum is not a guarantee of payment by my insurance.
- I understand and accept that I am ultimately financially responsible for all amounts not covered by my health insurance, including (but not limited to) co-payments, deductible, co-insurance, and other fees.
- Discounts for copays and deductible amounts are not allowed by law.
- I understand and agree that I am responsible for the payment of all charges incurred regardless of any insurance coverage or other plans available to me.
- I understand that Success On The Spectrum will bill me monthly for balances left unpaid by my health insurance. Invoices must be paid within 15 days of the date on the invoice.
- If any of my invoices remain unpaid for over 90 days, my child's services may be terminated.

ADDITIONAL FEES:

- Annual registration fee (non-refundable)
- Late fee for every 15 days that invoice payments are late
- Fee for each returned check (such as NSF)
- Mileage fees (for in-home and school shadowing services only)
- $50 nocall/noshow fee for unannounced cancellations
- field trip fees
- $25 late pick-up fee for each 15 minutes after your scheduled session has ended
- $1 per diaper if I do not supply my own to the center
- $5 forgotten lunch fee if I do not supply my own to the center (parents will be called to give permission to SOS to supply food to the child)
- Replacement fees for SOS electronics when damaged by your child
- Processing fees for payments made online
- any and all collections costs and/or attorney's fees if any delinquent balance is placed with an agency or attorney for collection, suit, or legal action.

INVOICE DISPUTES:

- If I believe there is an error on my invoice, I must contact the billing department within 90 days of receipt of the relevant invoice in order to allow review and consideration.
- Inquiries/Disputes regarding invoices over 90 days old will be deemed untimely and payment will be not be refunded.

*Parent's Name:	
*Parent's Signature:	
*Parent's Social Security:	
*Parent's Birthday:	
*Date:	

SUCCESS ON THE SPECTRUM

INFORMED CONSENT FOR SERVICES

Print Child's Name:	
Parent's Name:	

I hereby voluntarily apply for and consent to behavioral services by the staff of Success On The Spectrum. This consent applies to myself and the child named above.

I understand that parental involvement and trainings are required. I understand that Success On Spectrum encourages both parents to attend the required meetings.

I understand that my child's attendance is essential to the program and must be maintained at a level of 85% of scheduled sessions each month, and over the duration of enrollment.

I give permission to SOS to capture images/audio of my child while in the center. I also give permission to SOS to display these images/audio in the parent viewing room. I understand that other clients/parents/visitors may see these images/audio from the display in the parent viewing room.

I understand that I may ask for a referral to another professional if I am not satisfied with the progress of my treatment.

I understand that I have the right to refuse services at any time. I understand and agree that my continued participation implies voluntary informed consent. I also understand that Success On The Spectrum has the right to refuse services at any time.

Custodial Parent's Signature:	
Date:	

SUCCESS ON THE SPECTRUM

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Print Child's Name:	
Parent's Name:	

Health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth,", this means that I may be evaluated and treated by a health care provider or specialist from a different location.

Since this is different than the type of consultation with which I am familiar, I understand and agree to the following:

1. The consulting health care provider or specialist will be at a different location from me.
2. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and presenting practitioner. I will give my verbal permission prior to additional personnel being present.
3. Video recordings may be taken of the telehealth consultation. Video recordings and other data, including documents, images, and photos may be kept, viewed, and used for purposes including teaching, training, technical, scientific, research, or administrative purposes.
4. The health care provider will keep a record of the consultation in my medical record.

Noting all the above, I understand that my participation in the process described (called "telemedicine" or "telehealth") is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data. I further understand that I have the right to:

1. Refuse the telehealth consultation, or stop participation in the telehealth consultation at any time.
2. Limit any physical examination proposed during the telehealth consultation.
3. Request that the presenting practitioner refrain from transmitting my information if I make the request before the information is transmitted.
4. Request that nonmedical personnel leave the room(s) at any time.
5. Request that all personnel leave the room(s) to allow a private consultation with the off-site specialist(s).

I acknowledge that the health care providers involved have explained the consultations in a satisfactory manner and that all questions that I have asked about the consultations have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

Custodial Parent's Signature:	
Date:	

SUCCESS ON THE SPECTRUM

SECURITY SYSTEM WAIVER

Print Child's Name:	
Parent's Name:	

SOS uses video/audio surveillance at every center. Thes recordings are stored on a password protected hard drive within the center for a limited time before being written over.

These images/audio will not be used for marketing, advertising, or any public manner. These images/audio may be used for employee or parent training purposes.

Parents may view the live video feed at any time from our parent viewing room.

_____ initials

I grant Success On The Spectrum (SOS) non-revocable permission to capture and store my child's image and audio in video surveillance, motion pictures, and recordings while in the SOS center.I acknowledge that SOS will own such images/audio and further grant SOS permission to store and use these images/audio. I further waive any right to inspect or approve the use of the image/audio by SOS prior to its use.

_____ initials

SOS policy does not allow parents to take pictures/videos/audio while inside the building. SOS policy does not allow anyone to possess any pictures/videos/audio from our surveillance unless mandated by court order.

_____ initials

Inside our center, there are video cameras that record video/audio and display them in the parent viewing room. By signing this agreement, you give permission to display the live feed in the parent viewing room, where other parents/visitors may see or overhear your child.When clients/parents/visitors come into the center, it is possible that they see other clients or overhear their ongoing treatment. By signing this agreement, you agree to keep confidential all information obtained by your presence concerning other clients.

_____ initials

When you come into the parent viewing room, it is possible that you see and hear other children on the TV. By signing this agreement, you agree to keep confidential all information obtained by your presence concerning other clients.

I forever release and hold the SOS harmless from any and all liability arising out of the use of the images/audio for training purposes, and waive any and all claims and causes of action relating to use of the images/audio, including without limitation, claims for invasion of privacy rights or publicity.

Parent's Signature:	
Date:	

SUCCESS ON THE SPECTRUM

RELEASE OF LIABILITY

Print Child's Name:	
Parent's Name:	

This Voluntary Waiver and Release Agreement ("Release") is hereby executed by the undersigned parent, on his or her behalf and on behalf of the Child identified above, and each of their respective heirs, agents, executors, representatives, successors and assigns (collectively "Releasees") in favor of and for the benefit of Success On The Spectrum, as well as the employees, owners, agents, shareholders, members, contractors, parent companies, subsidiaries and affiliates of each of them (collectively "SOS"). Releasees will attend certain behavioral training administered by Success On The Spectrum at the SOS clinic and/or in Releasees' home (the "Services"). As a condition of receiving the Services, and prior to receiving any such Services, Releasees must execute this Voluntary Waiver and Release.

1. Releasees hereby assume all risk of accidents, personal injury, death and property loss and/or damage sustained or incurred by Releasees in connection with the Services, including, where permitted under applicable law, those caused as a result of negligence on the part of Releasees or actions of others present at the SOS clinic. Releasees acknowledge that it is their sole responsibility to evaluate carefully the risks inherent in visiting the Businesses' location and receiving the Services, and that Releasees have fully considered those risks, including, without limitation, dangers posed by the negligence or other conduct of Releasees or others present at the Businesses' location.

2. Releasees agree to and hereby do release, discharge, waive, indemnify and hold harmless SOS from and against all liabilities, actions, causes of actions, suits, damages, losses, judgments, claims and demands whatsoever, in law or in equity, including legal fees and costs, which Releasees may now or hereafter have against any SOS arising out of or in any way related to Releasees' presence at SOS clinc or the Services,
including, where permitted by applicable law, those caused by the negligence of SOS, or the negligence and/or conduct of others present at the SOS clinic, and including but not limited claims for personal injury, death or property damage.

3. Releasees covenant and agree not to institute or bring any suit or action at law, or otherwise, against SOS, or in any way aid in the institution or prosecution of any claim, demand, action or cause of action for damages, costs, loss of services, expenses or compensation against SOS for or on account of any damage, loss or injury to Releasees and/or Releasees'; person or property, or both, resulting from or related to the Releasees' presence at the SOS clinic or the Services.

4. Releasees acknowledge and understand that the Business and all other SOS franchisees are independently owned and operated business and are not owned by SOS Franchising, LLC. Releasees agree that if any portion of this Release is held invalid, the remaining portions and/or provisions shall be binding and continue in full force and effect.

_____
initial

I give my child permission to play on the playground/trampoline/monkey bars with the enclosed safety net while at Success On The Spectrum, with the understanding that there will be an adult present while he/she is doing so. I acknowledge that use of a trampoline can be dangerous and may result in serious injury or death if policies are not followed.

_____
initial

Occasionally, Clients may bring personally owned property (such as communication boards, iPads/tablets, iPods, specialized games, blankets, toys, etc.) into the center. I understand that SOS is not responsible for any damage/loss/theft to my property.

_____
initial

I hereby release Success On The Spectrum from any liability/claims/demands related to any loss/damage/injury to any of my personally owned property that my child may cause during in-home therapy sessions.

Releasees certify that Releasees have read this Release, fully understand it, and are not relying on any statements or representations made by SOS. Parents execute this Release knowingly and voluntarily.

Custodial Parent's Signature:	
Date:	

SUCCESS ON THE SPECTRUM

HEALTH INFORMATION DISCLOSURE

Print Child's Name:	
Child's Birthday:	

Confidentiality is a top priority at Success On The Spectrum, LLC. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy. For more information on privacy laws, please read Privacy Act of 1974 (Public Law 93-579)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

If I fail to specify an expiration date, event or condition, this authorization will not expire until treatment is terminated.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Doctor's Name:	
Doctor's Fax:	
Authorization Start Date:	
Authorization Expiration: (if any)	

I hereby give permission for Success On The Spectrum permission to **receive and share** my child's health information with all those listed above. I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at Success On The Spectrum.

Parent's Name:	
Parent's Signature:	
Date:	

SUCCESS ON THE SPECTRUM

PARENT HANDBOOK AGREEMENT

Print Child's Name:	
Parent's Name:	

COMPLAINTS

SOS is a national franchise. Each location is individually owned and operated.
Please address all concerns to the CEO and/or manager of your location.

If you do not find a satisfactory resolution, you may submit a complaint to SOS corporate office at https://successonthespectrum.com/complaint-form/. We will immediately launch an investigation. Written reports of the results and recommendations will be forwarded to you within 15 business days.

If you feel that your privacy rights have been violated, you have the right to complain to the US Department of Health and Human Services.

CLIENT RIGHTS

SOS promotes client rights that include, but are not limited to:

- Equal Admissions Opportunity (regardless of age, sex, ethnicity, or religious background)
- Confidentiality and privacy
- Interactions that are sensitive to your culture
- Freedom from physical and psychological abuse/neglect
- Freedom from unnecessary restraint
- Participate in individual planning, decision making, and implementation of treatment
- Personal dignity
- Personal safety
- Services provided in the most appropriate, least restrictive environment
- Accept or refuse services
- Decline to participate in research
- Offer complaints and receive timely, appropriate responses
- Receive information in an understandable manner on the results of evaluations, examinations, and treatments
- Religious freedom
- Access to your child's medical records
- Translation services, if needed

IN-CENTER THERAPY SESSIONS

BEFORE YOUR SESSION

- Children should be dressed and fed prior to drop off at our center (unless these skills are being addressed in the program).
- SOS is not liable for children outside of the checked-in hours. Parents are responsible for children in the parking lot or anywhere outside of the SOS center.
- Due to safety reasons, SOS does not provide any meals or snacks for the children. All students are expected to pack a lunch and re-usable water bottle.. Parents are responsible for notifying the facility, in writing, of any allergies or other medical conditions upon enrollment or as the parents become aware of them.
- Clients enrolled in SOS are not required to be toilet-trained, but parents are required to send in the appropriate diapering and/or toileting supplies that their child may need in their backpack. This includes diapers, wipes, creams, changes of clothing, and gloves to allow our staff of minimum of 3 changes per day.
- Parents are responsible for supplying the child's medications, and must complete the medical administration form.
- Children do not learn when they are unhappy, bored or stressed. It is our job to motivate your child to learn! Let us know what rewards your child is likely to enjoy. We request parents provide an assortment of their child's favorite items.
- Animals/pets are not permitted in therapy areas or hallways without approval.
- Attendance must be maintained at a level of 85% of scheduled sessions each month, and over the duration of enrollment. Extended vacations are not allowed, as it disrupts the progress of therapy.

DURING YOUR SESSION

- Parent must complete the sign-in form at the beginning of each session. Parents are responsible for ensuring accuracy of hours.
- Therapists may use the first and last 15 minutes of the session for set-up and clean up.
- Occasionally, clients may bring personally owned devices (such as communication boards, iPads, iPods, specialized games, etc.) into the center. Before any client-owned equipment/devices are brought on-site, a release of liability form must be completed by the parent. Parents are financially responsible for damage caused by your child to SOS property or a SOS employee's property. SOS is not responsible for any damage done by your child to your property
- You are welcome to view your child's session on our video security system from our Viewing Room. All non-client minors in our center (such as siblings) must be accompanied by an adult at all times.

AFTER YOUR SESSION

- Parent must complete the sign-out form at the end of each session.
- SOS will charge a $25 late pick-up fee for each 15 minutes after your scheduled session has ended.
- Prior to someone other than a parent picking up a child from our center, parents must fill out a form to authorize them to do so. SOS reserves the right to ask for their ID.
- Parents will receive a Daily Report about the progress made within the session.
- SOS requires parents to participate in Caregiver Training. Parents will be given "homework assignments" and will be frequently contacted about these assignments.

IN-HOME THERAPY SESSIONS

BEFORE YOUR SESSION

- Children should be dressed and fed prior to the session (unless these skills are being addressed in the program).
- Prepare an area in your home to be used for therapy. It must be a comfortable temperature, well lit, and relatively free of distractions.
- Children do not learn when they are unhappy, bored or stressed. It is our job to motivate your child to learn! Let us know what rewards your child is likely to enjoy. We request parents provide an assortment of their child's favorite items.
- A parent or responsible adult must be present at all times during therapy sessions. SOS employees are not allowed to change diapers, undress, or bathe a child. If needed, parents will also be the one to administer any first aid to your child.
- If a therapists arrives at your home and you are not present, they will wait 30 min before leaving. You will be charged a $50 noshow fee and applicable mileage fees.
- Attendance must be maintained at a level of 85% of scheduled sessions each month, and over the duration of enrollment. Extended vacations are not allowed, as it disrupts the progress of therapy.

DURING YOUR SESSION

- Parent must complete the sign-in form at the beginning of each session. Parents are responsible for ensuring accuracy of hours.
- Therapists may use the first and last 15 minutes of the session for set-up and clean up
- SOS Therapists are not obligated to work with siblings. If a therapist feels a sibling can be used as a participant in a session, it is at their discretion.
- Parents are financially responsible for damage caused by your child to SOS property or a SOS employee's property. SOS is not responsible for any damage done by your child to your property.
- If your child needs to be transported, it will be the responsibility of the parent or guardian to do this. SOS employees are not allowed to take a child in their automobile at any time.

AFTER YOUR SESSION

- Parent must complete the sign-out form at the end of each session.
- Parents will receive a Daily Report about the progress made within the session.
- Do not allow your child to play with SOS therapy materials and reinforcers outside of therapy time.
- SOS requires parents to participate in Caregiver Training. Parents will be given "homework assignments" and will be frequently contacted about these assignments.

Parent Signature:	
Date:	

SUCCESS ON THE SPECTRUM

AUTHORIZATION FOR PICK UP

Print Child's Name:	
Print Child's Birthdate:	
Custodial Parent's Name:	

SOS only allows a biological parent to pick up their child from our center (unless a court order states otherwise), regardless of who dropped the child off or their relation to the child.

In an effort to protect our clients, SOS asks that you let us know, in advance, who has your permission, other than you, to pick up your child from our center. You may pre-authorize individuals by listing them below. Please let these individuals know that they may be asked to show photo identification if a staff member is unfamiliar with them.

THE FOLLOWING ADULTS ARE AUTHORIZED TO PICK UP MY CHILD FROM SUCCESS ON THE SPECTRUM:

Name:	Phone:
Name:	Phone:
Name:	Phone:

I hereby give permission for my child to be picked up from the listed individuals.
I understand that my child will not be released to any individual that is not listed on this form.

Custodial Parent's Signature:	
Parent # 2 Signature: (optional)	
Date:	

SUCCESS ON THE SPECTRUM

TRAUMA SCREENING

Print Child's Name:	
Print Child's Birthdate:	

SOS desires to provide trauma informed care for every child. We understand that every child's past experiences will impact their current behavior. Without understanding their trauma history, we are at risk of unknowingly triggering previous trauma reactions. We understand that these situations are difficult for parents to discuss, so we will always do our best to respect your boundaries. We do ask that you be as open as possible in this form so that we can properly interact with your child and respect his/her past experiences.

Mark YES if it happened to your child to the best of your knowledge. Mark NO if it didn't happen to your child.

Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire	☐ yes	☐ no
Serious accident or injury like a car/bike crash, dog bite, or sports injury.	☐ yes	☐ no
Threatened, hit or hurt badly within the family.	☐ yes	☐ no
Threatened, hit or hurt badly in school or the community.	☐ yes	☐ no
Attacked, stabbed, shot at or robbed by threat	☐ yes	☐ no
Seeing someone in the family threatened, hit or hurt badly.	☐ yes	☐ no
Seeing someone in school or the community threatened, hit or hurt badly.	☐ yes	☐ no
Someone doing sexual things to the child or making the child do sexualthings to them when he/she couldn't say no. Or when the child was forced or pressured	☐ yes	☐ no
On line or in social media, someone asking or pressuring the child to do something sexual. Like take or send pictures	☐ yes	☐ no
Someone bullying the child in person. Saying very mean things that scare him/her.	☐ yes	☐ no
Someone bullying the child online. Saying very mean things that scare him/her.	☐ yes	☐ no
Someone close to the child dying suddenly or violently.	☐ yes	☐ no
Stressful or scary medical procedure	☐ yes	☐ no
Being around war.	☐ yes	☐ no

Been kicked out of a school or daycare due to autism-related challenges or challenging behavior	☐ yes	☐ no
Attended a clinic or school that used frequent punishment procedures with your child for their Challenging behaviors	☐ yes	☐ no
Attended a clinic or school in which they were frequently placed into a restraint in response to Their challenging behaviors	☐ yes	☐ no
History of neglect (e.g. not being fed, being left alone for periods of time, etc)	☐ yes	☐ no
Has been adopted	☐ yes	☐ no
Has been in the foster care system	☐ yes	☐ no
Was alive when parents went through separation or divorce	☐ yes	☐ no

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks:

	Never	Once in a while	Half of the time	Almost Always
Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	☐	☐	☐	☐
Bad dreams related to a stressful event	☐	☐	☐	☐
Acting, playing or feeling as if a stressful event is happening right now.	☐	☐	☐	☐
Feeling very emotionally upset when reminded of a stressful event.	☐	☐	☐	☐
Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	☐	☐	☐	☐
Trying not to remember, talk about or have feelings about a stressful event.	☐	☐	☐	☐
Avoiding activities, people, places or things that are reminders of a stressful event	☐	☐	☐	☐
Increase in negative emotional states (afraid, angry, guilty, ashamed, confusion).	☐	☐	☐	☐
Losing interest in activities s/he enjoyed before a stressful event. Including not playing as much.	☐	☐	☐	☐
Acting socially withdrawn.	☐	☐	☐	☐
Reduction in showing positive feelings (being happy, having loving feelings).	☐	☐	☐	☐
Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	☐	☐	☐	☐

Being overly alert or on guard.	☐	☐	☐	☐
Being jumpy or easily startled	☐	☐	☐	☐
Problems with concentration.	☐	☐	☐	☐
Trouble falling or staying asleep.	☐	☐	☐	☐