centre FOR autism services ALBERTA

PUF

APPLICATION

Office Use Only
Start Date:_____
Team:_____
Initials:_____

Date of Application (mm/dd/yyyy) _____

CHILD'S INFORMATION

CHILD'S LAST NAME	CHILD'S FIRST NAME		
GENDER ☐ Male ☐ Non-binary ☐ Female	BIRTH CERTIFICATE #	DATE OF BIRTH (mm/dd/yyyy)	
ADDRESS	CITY	PROVINCE	POSTAL CODE
Has your child gone through Preschool Assessment Services (PAS) at the Glenrose? ☐ Yes ☐ No	IF YES, DATE OF ASSESSMENT (mm/dd/yyyy)		
IF NO, PLACE YOUR CHILD WAS ASSESSED	DATE OF ASSESSMENT (mm/dd/yyyy)		

PARENT(S) / GUARDIAN(S) INFORMATION

MOTHER'S/GUARDIAN'S LAST NAME	MOTHER'S/GUARDIAN'S FIRST NAME	EMAIL ADDRESS	
HOME PHONE #	CELL PHONE #	WORK PHONE #	OCCUPATION
FATHER'S/GUARDIAN'S LAST NAME	FATHER'S/GUARDIAN'S FIRST NAME	EMAIL ADDRESS	
HOME PHONE #	CELL PHONE #	WORK PHONE #	OCCUPATION

Who has legal decision making authority for the child?

Who has legal custody of the child?

Custody arrangements, if applicable. *Please explain and attach documents*

Name of person(s) the child may **NOT** be released to:

FAMILY INFORMATION

PRIMARY LANGUAGE SPOKEN AT HOME	OTHER LANGUAGE(S) SPOKEN	
FAMILY'S IDENTIFIED CULTURE(S)	COUNTRY OF ORIGIN	LENGTH OF STAY IN CANADA (if not born in Canada)

PEOPLE WHO RESIDE IN YOUR HOME (parents, siblings (ages), others)

Are any of the following barriers for you in accessing services at the Centre? (please check all that apply)

☐ Childcare ☐ Issues with transportation ☐ Distance from the Centre

☐ Available time ☐ Others _____

Do you consider yourself a low-income family requiring financial assistance for resources or groups? ☐ Yes ☐ No

4752 – 99 Street ◊ Edmonton, AB T6E 5H5 ◊ T 780-488-6600 ◊ F 780-488-6664
www.centreforautism.ab.ca ◊ info@centreforautism.ab.ca

FSCD INFORMATION	
Have you been approved for Specialized Services? ☐ Yes ☐ No	IF YES, WHEN (mm/dd/yyyy)
If No, where in the process are you?	
FSCD NUMBER	CASE WORKER'S NAME

PUF / SCHOOL INFORMATION	
Has your child ever received PUF? ☐ Yes ☐ No	FOR HOW MANY YEARS?
NAME OF PRESCHOOL(S) OR KINDERGARTEN(S) previously attended	
Is your child currently in PUF? ☐ Yes ☐ No	NAME OF CURRENT PRESCHOOL/KINDERGARTEN
Will your child be PUF eligible this coming Sept? ☐ Yes ☐ No	NAME OF PRESCHOOL/KINDERGARTEN child will attend (if known)
PRESCHOOL/KINDERGARTEN ADDRESS	TEACHER or PRINCIPAL NAME
TEACHER or PRINCIPAL PHONE NUMBER	TEACHER or PRINCIPAL EMAIL
DAYS and TIME CHILD WILL ATTEND	

OTHER AGENCIES	
AGENCIES OR PROGRAMS YOUR CHILD HAS **PREVIOUSLY** BEEN INVOLVED IN	LIST ALL AGENCIES OR PROGRAMS IN THE SPACE BELOW
AGENCIES OR PROGRAMS YOUR CHILD IS **CURRENTLY** INVOLVED IN	LIST ALL AGENCIES OR PROGRAMS IN THE SPACE BELOW

EMERGENCY CONTACT INFORMATION (other than parent/guardian)			
LAST NAME, FIRST NAME	HOME PHONE #	CELL PHONE #	RELATIONSHIP TO CHILD

CHILD'S HEALTH INFORMATION		
ALBERTA HEALTH CARE NUMBER	PHYSICIAN'S NAME	PHONE #

ALLERGIES (any known allergies including food)	
RELEVANT HEALTH INFORMATION	Provide any information that is useful to medical professional in case of emergency
OTHER MEDICAL/EMERGENCY REQUESTS	

IN CASE OF EMERGENCY

In case of emergency and in my absence, I authorize by my signature below that the staff of the Centre for Autism Services Alberta, and its subsidiary programs, may give my child emergency care on site or transport him/her to an outside location. All medical aid, above and beyond first aid, will be administered by public emergency response teams and by qualified medical personnel only.

I give consent to Centre for Autism Services Alberta staff to arrange for any medical treatment and/or ambulance should it be required in the event of an illness or injury. I understand that payment for this service is my responsibility.

SIGNATURE_____ DATE (mm/dd/yy)_____

SIGNATURE OF WITNESS_____ DATE (mm/dd/yy)_____

Please email completed application form to
Joanne Fodchuk | jfodchuck@centreforautism.ab.ca