centre FOR autism services ALBERTA

PUF APPLICATION

Centre-Based Services, Edmonton

Please send these documents with this application:

☐ **Diagnosis report (SLP, Dr, etc.)**

☐ **Copy of birth certificate**

☐ **Copy of previous IPP (if applicable)**

Date of Application (mm/dd/yyyy) _____

CHILD'S INFORMATION

CHILD'S LAST NAME	CHILD'S FIRST NAME	
GENDER (please circle one) Male ◯ Female ◯ Non-binary ◯	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, please list all other assessments completed (SLP, OT, PSYCH ETC)	DATE OF ASSESSMENT(S) (mm/dd/yyyy)	

PARENT(S) / GUARDIAN(S) INFORMATION

1) PARENT/GUARDIAN NAME (First name, Last name)			2) PARENT/GUARDIAN NAME (First name, Last name)		
HOME PHONE #	CELL PHONE #	WORK PHONE #	HOME PHONE #	CELL PHONE #	WORK PHONE #
EMAIL ADDRESS			EMAIL ADDRESS		
OCCUPATION	PLACE OF EMPLOYMENT		OCCUPATION	PLACE OF EMPLOYMENT	
CURRENTLY WORKING? (√) YES☐ NO☐ If Yes: Full Time☐ Part Time☐ Shift work☐			CURRENTLY WORKING? (√) YES☐ NO☐ If Yes: Full Time☐ Part Time☐ Shift work☐		
PRIMARY LANGUAGE SPOKEN			PRIMARY LANGUAGE SPOKEN		
OTHER LANGUAGES SPOKEN			OTHER LANGUAGES SPOKEN		
IF ENGLISH AS SECOND LANGUAGE: (circle one) 1 – Little to none ◯ 2 – Basic skills ◯ 3 – Speak fluently ◯ Read English? (√) Y☐ N☐ Write in English? Y☐ N☐			IF ENGLISH AS SECOND LANGUAGE: (circle one) 1 – Little to none ◯ 2 – Basic skills ◯ 3 – Speak fluently ◯ Read English? (√) Y☐ N☐ Write in English? Y☐ N☐		
IDENTIFIED CULTURE	LENGTH OF TIME IN CANADA		IDENTIFIED CULTURE	LENGTH OF TIME IN CANADA	

EARLY CHILDHOOD SERVICES (ECS) INFORMATION

Has your child ever received Early Childhood Supports - Program Unit Funding (PUF)? ☐ Yes ☐ No	FOR HOW MANY YEARS?:	Will your child be PUF eligible this coming Sept? (2;8 mths-5;11 Sept.1) ☐ Yes ☐ No
NAME OF PRESCHOOL(S) OR KINDERGARTEN(S)		
Is your child currently in PUF? ☐ Yes ☐ No		
IF YES, PLEASE LIST PROGRAM NAME:_____		

TRANSPORTATION

Do you need transportation for your child? (√) Y____☐____ N____☐_____
If YES, please provide pick up and drop off address:

Pick Up:_____ Drop off:_____

Please note that CFASA cannot guarantee transportation until all class enrolment is complete.

FAMILY INFORMATION

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:

PEOPLE WHO RESIDE IN CHILD'S HOME (check all that apply)

CHECK ALL THAT APPLY	√	*LIST NAMES AND AGES AS APPROPRIATE*
Parent 1	☐	
Parent 2	☐	
Siblings	☐	
Grandparents	☐	
Aunt/Uncle	☐	
Others	☐	

OTHER AGENCIES

AGENCIES OR PROGRAMS YOUR CHILD IS **CURRENTLY** INVOLVED IN	DAYCARE or OUT OF SCHOOL CARE		
	Name:	Start Date:	End Date:
	Other agency/program names:		
	Name:	Start date:	End date:
	Name:	Start date:	End date:
AGENCIES OR PROGRAMS YOUR CHILD HAS **PREVIOUSLY BEEN** INVOLVED IN	Agency/Program		
	Name:	Start date:	End date:
	Name:	Start date:	End date:

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	Please list any additional diagnoses, hospitalizations or referrals and include DATES:

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 them 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 | jfodchuk@centreforautism.ab.ca

4752 – 99 Street, Edmonton, Alberta T6E 5H5 T 780.488.6600 F 780.488.6664
E info@centreforautism.ab.ca www.centreforautism.ab.ca

Charitable Number 872973995 RR0001