centre FOR autism services ALBERTA

PUF APPLICATION

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 check one) Male ◯ Female ◯ Non-binary ◯	BIRTH CERTIFICATE NUMBER	DATE OF BIRTH:	
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)		
If you have not had any assessments, we can provide SLP assessments between March and July. Would you be interested in an assessment? (√) ☐ Yes ☐ No			

PARENT(S) / GUARDIAN(S) INFORMATION

1) PARENT/GUARDIAN NAME (First name, Last name)			2) PARENT/GUARDIAN NAME (First name, Last name)		
HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER	HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
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: (check one) 1 – Little to none ◯ 2 – Basic skills ◯ 3 – Speak fluently ◯ Read Englis? Y ☐ N ☐ Write in English? Y ☐ N ☐			IF ENGLISH AS SECOND LANGUAGE: (check one) 1 – Little to none ◯ 2 – Basic skills ◯ 3 – Speak fluently ◯ Read English? Y ☐ N ☐ Write in English? Y ☐ N ☐		
IDENTIFIED CULTURE / RELIGION / ETHNICITY	LENGTH OF TIME IN CANADA		IDENTIFIED CULTURE / RELIGION / ETHNICITY	LENGTH OF TIME IN CANADA	

EARLY CHILDHOOD SERVICES (ECS) INFORMATION

There are 2 morning and 2 afternoon classes. Classes run Monday-Thursday for 3 hours. No school on Fridays. Please indicate your preference below by checking the box. Please note your preference is NOT GUARANTEED as we will need to ensure a balanced number of students in each class.

I would prefer for my child to attend in the:

- ☐ Morning: 8:30-11:30
- ☐ Afternoon 12:30-3:30

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? (2yrs 8 mths - 5yrs 11 mths Sept.1) YES ☐ NO ☐

NAME OF PRESCHOOL(S) OR KINDERGARTEN(S) PREVIOUSLY ATTENDED:

Is your child currently in PUF? ☐ YES ☐ NO

IF YES, PLEASE LIST PROGRAM NAME:

TRANSPORTATION

Would you like to apply for transportation for your child?If YES, please provide pick up and drop off address: ☐ YES ☐ NO

Pick Up:_____ Drop Off:_____

Please note - transportation IS NOT GUARANTEED.

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 NUMBER	CELL PHONE NUMBER	RELATIONSHIP TO CHILD

CHILD'S HEALTH INFORMATION

ALBERTA HEALTH CARE NUMBER	PHYSICIAN'S NAME	OFFICE PHONE NUMBER

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/yyyy)_____

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