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 #	DATE OF BIRTH (mm/dd/yyyy)

ADDRESS	CITY	PROVINCE	POSTAL CODE

Has your child gone through Infant Preschool Assessment Services (IPAS) 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 (Last name, First name)			2) PARENT/GUARDIAN NAME (Last name, First 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: (check 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: (check 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

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

Morning: 8:45-11:45______________________

Afternoon: 12:45-3:45_____________________

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? (2y;8months-5y;11months on 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? (√) Y___________ N_____________
If YES, please provide pick up and drop off address:

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:

Name of additional person(s) other than legal guardian(s) and emergency contact(s) who may pick up child from school:

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:

Last reviewed: January 2024

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/yyyy)_______________________________

SIGNATURE OF WITNESS____ DATE (mm/dd/yyyy)_______________________________

centre FOR
autism
services
ALBERTA

#200, 2415 Pegasus Rd NE
Calgary, AB T2E 8C3
T 780-488-6600 ext. 261
E info@centreforautismab.ca

Last reviewed: January 2024