Wendell Foster's Campus-Kelly Autism Program

APPLICATION

Parents & Guardians:

We appreciate your interest in Wendell Foster's Campus-Kelly Autism Program and the services we provide. Our services are designed to assist elementary school through young adults diagnosed in the Autism Spectrum Continuum as well as their families. The overall Kelly Autism Program has broad goals: transition to work, educational support, social skill refinement, community involvement, and family assistance. We offer programs for elementary, middle and high school students, as well as for individuals who may no longer be enrolled within an educational environment or may be transitioning into a vocation and/or seeking continued social skills.

Please fully complete the forms and return them to the address below. Providing the requested information will accomplish two necessary things: it will help us design the best program for your child; and it will help us gather data that will be invaluable in future programmatic decisions.

Upon receipt of your application we will review your information. After review of the application, we will contact you on whether KAP-at this time-will conduct an Intake Meeting with you and your student. The Intake Meeting will allow family members, students and KAP staff to evaluate if the program is a safe and appropriate setting. During the Intake Meeting, we will address concerns you may have and identify your child's future goals, so we can jointly design a meaningful program. Please be advised that the Kelly Autism Program cannot provide transportation to any activities or events. Other parents participating in the Kelly Autism Program may assist with transportation if that is a concern.

In order to provide an appropriate environment for your student, KAP must have qualified and experienced staff members to ensure the goals of our students. We closely review applicants for employment who will fully be equipped to support students who have submitted an application to KAP. The safety of your student and KAP's staff is a number one priority. Additionally, in extraordinary occasions there may be needs of a participant that we may not be able to serve at this time.

Thank you for your interest in Wendell Foster's Campus-Kelly Autism Program. We look forward to hearing from you.

Sincerely,

Kristen Coomes, Program Manager
Wendell Foster's Kelly Autism Program

COMPREHENSIVE CONSENT FORM: PARENT/GUARDIAN- ***Please read this agreement thoroughly as some areas have changed.***

I, _____, give my permission for the staff of the Kelly Autism Program (KAP), at Wendell Foster's Campus to:

- ❑ 1. obtain my child's public school documents and records including the IEP;
- ❑ 2. conduct educational, behavioral, and other assessments with my child (BRIEF);
- ❑ 3. conduct observations of my child's educational, recreational, and work-related activities;
- ❑ 4. photograph, audiotape, and/or videotape such activities of my child as needed.

Please check all appropriate boxes above.

I certify that: (a) I am the parent or legal guardian of _____
(Please print child's full name)

(Check the appropriate blank) _____ PARENT _____ GUARDIAN;

(b) I may legally grant these permissions independent of the consent of any other individual or organizational entity.

By signing below, I indicate that I understand and agree with the following ethical guidelines, to which all members of the KAP staff will strictly adhere to while conducting all of the activity mentioned above.

I. INFORMED CONSENT
All aspects of the program design, prescribed interventions, and educational and other treatments will be explained to program participants (if applicable) and his/her parent(s) or guardian(s). Further, no component of any program, intervention, and/or treatment will be implemented with the participant unless prior verbal or written consent has been given by the undersigned.

II. PURPOSE
The specific purpose for conducting program activities will be made known to the participant (if applicable) and/or his/her parent(s) or guardian(s) either as part of established program procedures upon request.

III. FREEDOM OF PARTICIPATION/NON-PARTICIPATION
Consent to participate is completely voluntary and can be withdrawn at any time, either verbally or in writing, as the undersigned may desire. This agreement in no way binds the undersigned to work with KAP, and he/she is completely free to withdraw at any point.

IV. CONFIDENTIALITY

All identifying information gathered about a participant will be held in strict confidence. The KAP staff will only use this information for program-related purposes and will not release it in any form without the verbal request and written permission of the undersigned. Participant records will be in locked storage and upon the written and/or verbal request of the undersigned, will be returned to the undersigned or completely destroyed.

V. REASONABLE PROTECTION FROM PHYSICAL AND MENTAL STRESS, HARM, OR DANGER

- **Well-Being:**

The mental and physical well-being of the participant will be informally considered through an Intake Meeting before any program component begins and periodically reviewed during the process. If before or during a session the participant is deemed to be in a state of mental or physical distress (harming themselves or others), KAP staff will postpone the session and take an action deemed necessary [e.g., call parent(s) or guardian(s), request that parent (s) or guardian(s) remain with the participant during the session, or the student may need to exit the program until the student is no longer a harm to themselves or other participants or staff, seek medical help, etc.].

- **Breaks:**

As scheduled or as requested, breaks will be provided, and, at any significant sign of prolonged fatigue or stress on the part of the participant, any program component may be temporarily or permanently discontinued. At that point, the participant's ability and willingness to resume will be assessed, and the session will be immediately continued, continued after a break, ended until the next session (parent(s) or guardian(s) called to pick-up immediately), permanently discontinued, or ended until further notice from the undersigned, whichever KAP staff deems best for the overall well-being of the participant.

- **Safety:**

The term "reasonable protection" means that: (a) program processes will be conducted according to this document and (b) the KAP Program Manager and/or staff will not act in premeditated ways to cause mental and/or physical harm to participants.
"Reasonable protection" does not mean that KAP or any person or organization whether specifically or remotely associated with it can be held liable for: (a) any act committed by other persons or organizational entities while the participant is under the care and supervision of KAP staff; (b) anything legally defined as "as act of God" (e.g., dangerous weather conditions); (c) situations in which participants cannot reasonably be prevented from willfully engaging in dangerous behaviors (e.g., staff is unable to prevent the behavior due to a lack of proximity or physical strength); and/or (d) situations, conditions, outcomes, etc. in the clear domain of parent/guardian responsibility.

VI. KNOWLEDGE OF OUTCOME

The undersigned may request a complete report based on project activities and outcomes. This report will address agreed-upon goals and attempt to provide data regarding the rate of progress toward those goals.

Parent/guardian (PRINT):

_____

Parent/guardian (SIGN):

_____

Date of Content: _____

Student Application

Please drop off or mail completed forms to:
Wendell Foster's Campus
KAP
P.O. Box 1668
Owensboro, Kentucky 42302-1668

History Form

1) Participant's Full Name: _____Likes to be called:_____

2) Address: _____
(street)
_____
(city) (state) (zip)

3) Telephone number where you can be reached (home or other): _____

4) Participant's date of birth: _____ 5) Gender: M F

6) E-mail: _____

7) Client currently lives with: _____

8) Occupation of Parent/Guardian: _____

9) How did you learn about the program?
_____ Brochure
_____ Word of mouth
_____ Advisory Committee member
_____ Program Manger/staff member
_____ other, please specify _____

I. Information about your child:

1) Please list the participant's brothers and sisters

Name	Age	Grade	Gender	Health or other problems

MEDICAL HISTORY

2) Has your child seen any of these professionals in the **last 6 months** to a year?

	Family physician		Speech Pathologist
	Neurologist		Audiologist
	Dietician		Physical Therapist
	Psychiatrist		Occupational Therapist
	Psychologist		Ear, Nose, Throat Specialist
	Social Worker		Ophthalmologist

3) Name of Professional and Address:

1. _____
2. _____
3. _____
4. _____

4) Is your child **currently** taking medication(s) and/or vitamins?

Medication/vitamin	Administered by (i.e. injection, pill)	Dosage (mg)	Administration Schedule (i.e. time daily)

5) **Past** medications taken for disability-related purposes (exclude current):

Medication	Dates	Reason	Effectiveness

6) At what age did you first think something was wrong with your child? _____

7) At what age did you seek professional help? _____

8) From whom did you seek professional help? _____

Name and Address: _____

9) Has any other family member been diagnosed with a disability? _____

If so, what is the disability? _____

PLEASE FILL-OUT THIS SECTION COMPLETELY.

A. Speech

1) Please estimate your child's present vocabulary

_____ Receptive Language at age appropriate level
_____ Below age appropriate level
_____ Expressive Language at age appropriate level
_____ Below age appropriate level
_____ Child is verbal (Yes or No) If other, please explain.
_____ Child uses sign language
_____ Child uses Picture Exchange Communication System (PECS)
Independently or with assistance? How long has student used PECS?_____
_____ Child uses Alternate Augmentative Communication System or any assistive technology (e.g. iPad or the use of personalized methods or devices to supplement student's ability to communicate)
How long has student used assistive technology?_____

****Below, please check all that apply. Indicate "n/a" if the area is not applicable.****

Current	**Past**	
_____	_____	no speech currently (yes or no)
_____	_____	repeats questions instead of answering them
_____	_____	hard to understand what he/she is saying
_____	_____	unusual tone and pitch
_____	_____	has language of his/her own
_____	_____	doesn't seem to understand what is said to him without gestures
_____	_____	often ignores what is said to him/her (speech)
_____	_____	afraid of certain sounds
_____	_____	really likes certain sounds (for example, music or motors
_____	_____	takes or needs your hand for help, or leads you to what he/she wants

B. Relating With Other People

Current	**Past**	
_____	_____	prefer to be by self
_____	_____	"in world of his/her own" world
_____	_____	ignore people generally
_____	_____	aloof, distant
_____	_____	"clings" to people
_____	_____	doesn't recognize parents
_____	_____	very fearful of strangers
_____	_____	doesn't interact with other peers
_____	_____	prefers to interact with younger children

C. Imitation

Current	Past	
_____	_____	doesn't imitate gestures (physical imitation)
_____	_____	doesn't repeat words said to him/her (verbal imitation)
_____	_____	doesn't repeat words generally, but usually will do what he/she's asked to do

D. Visual Response

Current	Past	
_____	_____	often avoids looking at people when they talking to him/her by lights-stares at certain ones
_____	_____	stares vacantly around the room
_____	_____	often doesn't look at anything
_____	_____	very interested in small parts of an object
_____	_____	likes to look at self in the mirror
_____	_____	likes to look at shiny objects
_____	_____	stares at parts of body – i.e., hands
_____	_____	seems to look at things out of the corner of his/her eyes and not looking directly at them
_____	_____	plays with turning lights on and off

E. Other Senses

Current	Past	
_____	_____	licks objects
_____	_____	tries to chew or eat objects which are not supposed to be eaten (i.e., clay)
_____	_____	doesn't seem to notice if something tastes bad
_____	_____	smells objects not usually smelled or smells unfamiliar objects
_____	_____	doesn't notice pains as much as most people
_____	_____	doesn't recognize parents
_____	_____	overreacts to pain
_____	_____	likes vibrations

F. Emotional or Physical Responses

Current	Past	
_____	_____	temper tantrums
_____	_____	moods change very quickly, sometimes for no apparent reason
_____	_____	often has a blank expression on face – little responses to what is happening around him/her
_____	_____	over-responds to situations
_____	_____	hits, bites, scratches, pinches, kicks, grabs self or others
_____	_____	laughs or smiles for no apparent reason
_____	_____	doesn't recognize parents
_____	_____	cries or seems sad for no apparent reason
_____	_____	doesn't interact with other peers
_____	_____	other, please describe _____

G. Body Movements

Current	Past	
_____	_____	rocks from foot to foot
_____	_____	rocks in bed or chair
_____	_____	holds hands in strange positions
_____	_____	wiggles hands or fingers in strange ways
_____	_____	has unusual posture
_____	_____	bites him/herself
_____	_____	bangs head
_____	_____	walks on tiptoes
_____	_____	nothing unusual about his/her use of his/her body

H. Use of Materials, Objects

Current	Past	
_____	_____	has strong attachment to a particular object
_____	_____	spins wheels or small parts of objects
_____	_____	dangles strings, straws, etc.
_____	_____	doesn't use objects for intended purposes
_____	_____	gets involved in a simple activity for long periods of time

I. Reaction to Change

Current	Past	
_____	_____	gets upset when routine changes
_____	_____	will wear only certain clothes

J. Eating

Current	Past	
_____	_____	likes only a few foods
_____	_____	has trouble chewing
_____	_____	poor appetite
_____	_____	aloof, distant

K. Anxiety and Fears

Current	Past	
_____	_____	gets overly upset by certain things or situations
_____	_____	not easily calmed
_____	_____	stays upset for a long time

L. Manageability

Current	Past	
_____	_____	engages in ongoing problem behaviors
_____	_____	engages in intermittent behaviors

II. Information About Your Child at School

1) School Status:

_____ high school _____ middle school _____ Other

2) School:

Name: _____

Teacher: _____

3) Grade level in school: _____

4) Please check appropriate column:

	Regular Classroom / No adaptations
	Regular Classroom / With adaptations
	Pull-out
	Resource Room
	Other-Self Contained

5) Is your child receiving any tutoring in school? _____

If so, how many hours per week and in which subject? _____

6) Is your child involved in any extracurricular activities? _____

7) How did you think your child is doing academically? _____

8) Does your child have any friends at school? _____

9) How do you think your child is doing socially? _____

III. Community

1) Does your child enjoy going places in the community? _____
If so, where? _____

2) Does your child enjoy shopping? _____
If so, where? _____

3) What does your child enjoy for recreation? _____

4) Does your child participate in volunteer work? _____

5) Does your child enjoy participating in art projects? _____
If so, what kind of art projects? _____

IV. The Kelly Autism Program and Your Expectations

The KAP provides educational support, social training, community involvement opportunities, and job coaching. What do you expect from the KAP if you enroll your child in our program?

_____
_____
_____
_____

To the parents or guardians of KAP Participants:

In order to better serve the KAP participants, we are in the process of constructing a chart of allergies of your child. Please send a list of allergies that your child has (certain foods, medications, eggs, dust, insect stings, peanuts, pets, artificial sweetener, latex, etc.). If you have any other concerns we are not already aware of, list them as well.

Thanks,
KAP staff

I, _____, grant the KAP staff permission to apply Triple Antibiotic Ointment to a minor topical cut or scrap on my child if they get accidentally hurt.

Allergies Other Issues

In Case of an Emergency

Participant _____

Parent / Guardian _____

Address _____

Home (Phone) _____ Business Phone _____

Cell Phone _____ E-mail _____

Secondary Contact Name _____
(To be used if the person above cannot be reached)

Address _____

Home (Phone) _____ Business Phone _____

Cell Phone _____ E-mail _____

Physician's Name _____

Address _____

Phone _____

Name of School _____

Classroom Teacher at School _____

Current Medications _____

I certify that I am the participant's legal parent/guardian and give the staff of the Kelly Autism Program my permission to obtain medical intervention as warranted for the client in the event that I cannot be reached.

_____ _____
Signature Date

Wendell Foster's Campus-Kelly Autism Program
Release and Waiver of Liability and Assumption of Risk Agreement

1. I, _____, desire to participate in the following employment transportation/community involvement activity/trip _____ _____ (hereinafter the "Activity"), scheduled to be held on or about _____. I understand and appreciate there may be dangers, hazards, and risks inherent in, associate with, or arising out of the Activity, the transportation to and from the Activity, acts by third parties unrelated to the Activity, activities not scheduled by WFC that are in addition to and not related to the Activity (collectively referred to as the "Risks"). I recognize that these Risks could result in injury, illness or property loss or even death.

2. In exchange for the right to participate in the Activity, I hereby assume all responsibility and liability for these Risks, whether known or unknown, direct or indirect. On behalf of myself, my family, and my successors and assigns, I hereby release, waive, discharge, and hold harmless Wendell Foster's Campus, its Board of Directors, officers, Advisory Committee, agents, employees, subcontractors, and/or employed by Wendell Foster's Campus (collectively referred to as "WFC"_ from and against any and all claims, demands, liabilities, controversies or cause of action, damages, costs, and/or expenses of any kind or nature whatsoever, that may hereafter accrues, relating to or arising out of the Activity, my participation in the Activity, and/or the Risks.

3. In the event of an accident or serious illness, I hereby authorize WFC to obtain medical treatment for me and on my behalf. I hereby hold harmless and agree to indemnify WFC from any claims, cause of action, damages and/or liabilities, arising out of or resulting from said medical treatment.
   In order to participate I am aware that I must have a copy of my current insurance card and a photo ID on my person during the field trip and authorize WFC to share my insurance and personal information with medical or other personnel.
   If I do not currently have medical insurance, I am aware that I will personally responsible for all expenses incurred for me and on my behalf.

4. In signing the Agreement, I acknowledge and represent that I have carefully read this Agreement and understand its contents and that I sign this document of my own free will. I further state that I am at least (18) years of age and fully competent to sign this Agreement, that there are no health-related reasons or problems which preclude or restrict my participation in the Activity and that I have adequate health insurance necessary to provide for and pay for any medical costs that may be required or rendered to me as a result of injure or illness.

5. If I drive while participating in this Activity, I hereby warrant, represent and certify that I personally carry Automobile Liability Insurance applicable and effective in the place in which I will driving, and that this insurance included medical payment coverage in the event of an

accident. I am aware that I or my insurance company will be responsible for all expenses incurred in the event of an accident.

In order to participate I must provide two emergency contacts and by providing these I authorize WFC to report medical and other personal information as deemed necessary by any WFC, medical, or other involved agents.

Name: _____ Name:_____

Relation: _____ Relation:_____

Phone Number:_____ Phone Number:_____

In the event of needing medical attention do you have any conditions or are you taking any types of medication that medical personnel need to be aware of?

YES _____ **NO _____**

If yes, please list:

_____

_____

_____

_____

_____

THIS IS A RELEASE OF LEGAL RIGHTS. BE CERTAIN YOU READ AND UNDERSTAND THIS RELEASE BEFORE SIGNING IT.

Signature: _____ Date: _____

Printed Name: _____

Please use this page to expand on specific reward systems currently in place at home and/or school. For behaviors indicated above in "Sections A thru L", please include specific soothing or calming techniques that are in place at home or school. Our goal is to complement what currently works for your student at home and/or school so we provide consistency for your student. IEP's are welcomed, also.