Fall SSS (Aug. – Dec) ____
Winter SSS (Jan. – May) ___
Camp Friendship: June ____
Camp Friendship: June ___
Camp Friendship: July ____

DATE: __________________

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SOCIAL SKILLS SUCCESS REGISTRATION
FOR SOCIAL SKILLS GROUPS/CAMP FRIENDSHIP/CAMP CONNECT

Parents' Names: ____
Child's Name: _________________________________ Date of Birth: ___________
School: ____
Grade in School: _______________________________Age: __________________
Address: ____
City: ____ Zip: __________________
Home Phone: __________________________Dad's Cell: _______________________
Work Phone: __________________________Mom's Cell: ______________________
E-Mail: ____

Siblings: ____
Allergies: ____
____
____
Diagnosis: ____
Referred By: ____
Therapists currently working with your child: ______________________________
____

Medications your child is currently taking and the dosage: __________________
____

Goals for your child: ____
____
____

I, ______________________________, give my permission for Gayle Born, Mary Jane Trotti or Jim Trotti in the event of an emergency to consult with other professionals regarding my child, _________________________. I give permission for my child to be transported by ambulance to Children's Healthcare of Atlanta for treatment.

Signature of Parent: __________________________________ Date: _____________

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Deposit paid: _________ Check #: _________ Date: ______________________