Social Skills Success Registration
For Groups or Camp Friendship

Parents' Names: _____ Date: _____

Child's Name: _____ DOB: _____

School: _____

Grade in School: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Dad's Cell: _____

Work Phone: _____ Mom's Cell: _____

Dad e-mail: _____ Mom e-mail: _____

Siblings: _____

Allergies: _____

Diagnosis: _____

Referred By: _____

Therapists currently working with your child: _____

_____

Medications/dosage your child is currently taking:

_____ _____ _____ _____

_____ _____ _____ _____

Goals for your child: _____

_____

_____

_____

_____

_____
Initials — I give my permission for Gayle Born and/or Mary Jane Trotti to consult with other professionals regarding my child.

_____
Initials — In the event of an emergency, I give permission for my child to be transported by ambulance to Children's Healthcare of Atlanta for treatment.

Signature of Parent: _____ Date: _____

Please make check payable to Gayle Born.

Deposit paid: _____ Check #: _____ Date: _____