FALL SSS (Sep - Dec) ____ **DATE: _____**
Group :
Day :
Time :

MAKE CHECK PAYABLE TO GAYLE BORN

SOCIAL SKILLS SUCCESS REGISTRATION

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: _____

MAKE CHECK PAYABLE TO GAYLE BORN

Deposit paid: _____ Check #: _____ Date: _____