



S.P.E.A.K.  
P.O. Box 296  
Wexford, PA 15090  
412-856-7223  
SPEAK@autismpittsburgh.org

*Summer Program for the Education of Autistic Kids*

*Program of Autism Pittsburgh*



## S.P.E.A.K. DATES FOR 2024

<b>July 1</b>	<b>First student day, full day</b>
July 2-3	In session
July 8-12	In session
July 15-19	In session
July 22-26	In session
July 29	In session
<b>July 30</b>	<b>Last day – half day for students</b>

Student	9 a.m. to 2 p.m.
Hours	8:15 a.m. to 2:15 p.m.
Staff Hours	

Location:	Saint Therese of Lisieux School 3 St. Therese Court Munhall, PA 15120
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Summer Program for the Education of Autistic Kids

# 2024 S.P.E.A.K. SUMMER PROGRAM APPLICATION FORM

**FOR SAFETY ATTACH RECENT PHOTO OF CHILD**

**REQUIRED** Social Security Number: \_\_\_\_\_

NAME OF CHILD \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

Number Street/Avenue City/State Zip Code

Parent/Caregiver's Names \_\_\_\_\_

Father Mother Other

Address \_\_\_\_\_

*(if different from child's)*

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Name/Relationship

\*\*Email address: \_\_\_\_\_

School District \_\_\_\_\_ Present School \_\_\_\_\_

School Address \_\_\_\_\_ Teacher's Name \_\_\_\_\_

Service Coordination Unit \_\_\_\_\_

Address \_\_\_\_\_

Name of Caseworker \_\_\_\_\_ Phone \_\_\_\_\_

Is child diagnosed ASD? \_\_\_\_\_ Other? \_\_\_\_\_

Who made diagnosis? \_\_\_\_\_ Where? \_\_\_\_\_ When? \_\_\_\_\_

**Does your child qualify for Extended School Year (ESY)? YES \_\_\_\_\_ NO \_\_\_\_\_**

If not, can you provide or make arrangements for transportation for your child to attend SPEAK?

YES \_\_\_\_\_ NO \_\_\_\_\_

T-Shirt Size \_\_\_\_\_

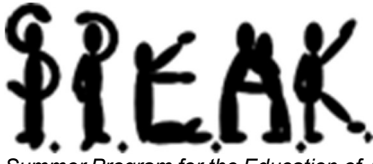
**IMPORTANT: PLEASE NOTE NEW ADDRESS**

**RETURN BY MAY 31, 2024 TO:**

**S.P.E.A.K.  
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Provider of Services for Autism Involved Individuals in the Greater Pittsburgh Area



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## 2024 S.P.E.A.K. SUMMER PROGRAM STUDENT INFORMATION FORM

*To be completed by parent or caregiver*

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parents/Caregiver's Name \_\_\_\_\_

Address \_\_\_\_\_  
Street/Avenue City State Zip Code

Home Phone Number \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Emergency Phone Number \_\_\_\_\_ Name/Relationship \_\_\_\_\_

1. Is your child toilet trained? YES \_\_\_\_\_ NO \_\_\_\_\_
2. If toilet training is an emerging skill for your child, describe the toileting schedule that is used.

3. Can your child feed himself/herself? YES \_\_\_\_\_ NO \_\_\_\_\_

4. Are there any problems for your child when eating? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, please specify.

Food allergies? YES \_\_\_\_\_ NO \_\_\_\_\_ Dietary restrictions? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, please explain.

5. Does your child have any particular fears? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, what are they and how are they handled?

6. What forms of communication does your child use?

7. What oppositional behavior does your child display?

8. What are your child's typical behaviors in community and on public transportation?

9. What intervention/reinforcement programs are used for these behaviors?
10. Does your child have a one-on-one aide assigned to him/her during the regular school year?  
 YES \_\_\_\_\_ NO \_\_\_\_\_
11. Does our child have a TSS (Therapeutic Support Staff) person assigned to him/her?  
 AT HOME YES \_\_\_\_\_ NO \_\_\_\_\_  
 IN SCHOOL YES \_\_\_\_\_ NO \_\_\_\_\_

What agency provides your child's wraparound services? \_\_\_\_\_  
 Contact/Supervisor's Name \_\_\_\_\_  
 Phone No. \_\_\_\_\_

12. What kinds of activities or items are reinforcing for your child?
13. Would you be interested in participating in a family day? YES \_\_\_\_\_ NO \_\_\_\_\_
14. Is there anything else that you would like us to know about your child?

Please check the following recreation/leisure activities in which your family participates, and you would like your child to learn:

BASKETBALL \_\_\_\_\_ BASEBALL \_\_\_\_\_ FOOTBALL \_\_\_\_\_  
 BOWLING \_\_\_\_\_ SOFTBALL \_\_\_\_\_ VOLLEYBALL \_\_\_\_\_  
 RUNNING/JOGGING \_\_\_\_\_ SWIMMING \_\_\_\_\_ AEROBICS \_\_\_\_\_  
 MINITURE GOLF \_\_\_\_\_

Which of the following are areas of interest for your child?

MUSIC \_\_\_\_\_ ART \_\_\_\_\_ COMPUTERS \_\_\_\_\_ READING \_\_\_\_\_  
 COOKING \_\_\_\_\_ CRAFTS \_\_\_\_\_ MOVIES \_\_\_\_\_ ANIMALS/PETS \_\_\_\_\_  
 OTHER \_\_\_\_\_

Please check the following community activities in which your family participates, and you would like your child to learn:

SHOPPING \_\_\_\_\_ LIBRARY \_\_\_\_\_ MOVIE THEATRE \_\_\_\_\_

ZOO \_\_\_\_\_ MUSEUM \_\_\_\_\_ PARKS \_\_\_\_\_

PLAYGROUND \_\_\_\_\_ RIDING BUS/SUBWAY \_\_\_\_\_

RESTAURANT (specify) \_\_\_\_\_

OTHER (specify) \_\_\_\_\_

Do you have any particular problems when you attempt to have your child participate in these activities?  
(Please describe)

Describe your child's behavior when crossing streets and walking on sidewalks.

**APPLICATION FORMS MUST BE RETURNED BY MAY 31, 2024**



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## S.P.E.A.K. SUMMER PROGRAM EMERGENCY MEDICATION DATA

Student \_\_\_\_\_ Parent's Name \_\_\_\_\_

Address \_\_\_\_\_ School District \_\_\_\_\_

Home Phone \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Person to contact in **CASE OF EMERGENCY** \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Second Emergency Name \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

Does your child require medication regularly? Circle One YES NO

If so, please list type and frequency: \_\_\_\_\_  
\_\_\_\_\_

If yes, give name, address and phone number of prescribing physician:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Please note any allergies including any know drug allergy (use additional paper if necessary)

\_\_\_\_\_  
\_\_\_\_\_

### EMERGENCY TREATMENT

In the event of an emergency, you will be notified. However, if we are unable to contact you, we request permission for the following: (1) use of antiseptics (2) notification of a local doctor if necessary and (3) transportation of your child to a hospital if warranted.

I hereby give my consent to the above request to administer emergency treatment. I will assume responsibility for any charges for the necessary treatment through insurance or by direct payment.

(Signature) \_\_\_\_\_



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Year 2024



Return by: MAY 31, 2024

## 2024 S.P.E.A.K. SUMMER PROGRAM AUTHORIZATION FOR FIELD TRIPS

### Circle One

YES            NO

To make it possible for my child to take full advantage of the S.P.E.A.K. Summer Program, I hereby give my permission for him/her to make field trips under the supervision of the S.P.E.A.K. staff.

Date \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Child \_\_\_\_\_

## 2024 S.P.E.A.K. SUMMER PROGRAM AUTHORIZATION FOR PICTURES

### Circle One

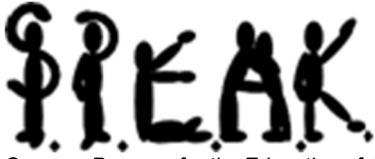
YES            NO    I hereby give permission for pictures and/or movies to be made of my child to be used or training professionals and/or parents.

YES            NO    I hereby give permission for picture and/or movies to be made to be used for public relations/publicity.

Date \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Child \_\_\_\_\_



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AUTISM  
PITTSBURGH

Year 2024



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**2024 S.P.E.A.K. SUMMER PROGRAM  
PARENTAL WAIVER TO RELEASE OR  
OBTAIN CONFIDENTIAL INFORMATION**

I hereby authorize the Autism Society of Pittsburgh, Inc. (S.P.E.A.K. Program) to secure or release to my child's school:

\_\_\_\_\_

And/or my child's Base Service Unit \_\_\_\_\_

Any information concerning (Child's Name) \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Child \_\_\_\_\_





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***Return by MAY 31, 2024***

**CHILD HEALTH STATUS FORM**  
**2024 S.P.E.A.K. SUMMER PROGRAM**  
**Must be COMPLETED and SIGNED by DOCTOR**

**CHILD'S NAME** \_\_\_\_\_

**1. Is the child free of communicable diseases?**

Yes \_\_\_\_\_

No \_\_\_\_\_

**2. Is the child physically able to participate in the S.P.E.A.K. Summer Program?**

Yes \_\_\_\_\_

No \_\_\_\_\_

**Comments: (if any)**

\_\_\_\_\_  
\_\_\_\_\_

**Current Medications and Dosages:**

\_\_\_\_\_  
\_\_\_\_\_

**Will medications need to be given during camp session, 9 a.m. – 2 p.m.**

Yes \_\_\_\_\_

No \_\_\_\_\_

**What medications?** \_\_\_\_\_

**When given?** \_\_\_\_\_

**Physician's Name** \_\_\_\_\_  
*(Print Clearly)*

**Address** \_\_\_\_\_  
*(Print Clearly)*

**Telephone Number** \_\_\_\_\_  
*(Print Clearly)*

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_