AUTISM ESCAPES FAMILY APPLICATION

BIOGRAPHICAL INFORMATION:

NAME OF CHILD:____

HOME ADDRESS:____

____

AGE OF CHILD: __________

WEIGHT: _______ HEIGHT: ________

CHILDS DIAGNOSIS:____

SCHOOL ATTENDING:____

GRADE: ___________

CONTACT INFORMATION:

NAME OF PARENT (S)/ GUARDIAN:____

EMAIL ADDRESS:____

PHONE NUMBER: ____

MEDICAL INFORMATION:

MEDICAL CONDITION:____

____

MEDICATIONS (INCLUDE SUPPLEMENTS) AND MEDICATIONS TAKEN ON AN "AS NEEDED" BASIS:____

____

____

ALLERGIES:____

____

DIETARY RESTRICTIONS?____

____

HAS YOUR CHILD EVER BEEN HOSPITALIZED?___________

DOES CHILD HAVE A SEIZURE DISORDER/ EPILEPSY? __________

- IF YES, WHAT TYPE OF SEIZURES?____
- HOW FREQUENTLY DO SEIZURES OCCUR?_____________________________________

- WHAT ARE THE TRIGGERS (IF KNOWN)?____________________________________
  ____

DOES YOUR CHILD HAVE FREQUENT EPISODES OF PAIN?_______________________

- IF SO, HOW DOES PAIN MANIFEST:____
  ____
  ____
  ____

LOCAL MD (name, address, specialty):______________________________________
____
____

NAME OF OUT OF TOWN MD:____

*REASON FOR OUT OF TOWN MD VISIT:____
____
____
____

*EXPLAIN WHY YOUR CHILD NEEDS TO SEE AN OUT OF TOWN MD AND WHAT HAS PROHIBITED YOU FROM TAKING YOUR CHILD THERE:_______________________
____
____
____
____
____
____
____
____
____

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TRAVEL INFORMATION:

WHO WILL ACCOMPANY CHILD ON TRIP (NAMES/ RELATIONSHIP TO CHILD):

1. ____
2. ____
3. ____

DOES CHILD HAVE DIFFICULTY SITTING IN SEAT FOR LONG CAR RIDES? _________

DOES YOUR CHILD ENJOY CAR RIDES? ____

MODE OF "RESTRAINT" ON CAR RIDES (SEAT BELT/ CAR SEAT/ ADAPTIVE DEVICE):

____

IS CHILD TOILET TRAINED?__________

*PLEASE EXPLAIN WHAT YOU WOULD IMAGINE WOULD BE THE "WORST CASE" SCENARIO ON BOARD THE PLANE SO THAT THE FLIGHT CREW CAN BE ADEQUATELY PREPARED: ____

____

____

____

____

____

____

HAS YOUR CHILD EVER FLOWN ON A COMMERCIAL AIRLINE?______________

- NUMBER OF FLIGHTS?_________

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*PLEASE SHARE YOUR EXPERIENCES WITH AIR TRAVEL AND/OR TRAVEL IN GENERAL:

____
____
____
____
____

*IF YOU HAVE NOT FLOWN WITH YOUR CHILD, WHAT HAS PREVENTED YOU FROM DOING SO? ____
____
____
____
____
____

*WHAT IS YOUR GREATEST FEAR (S) ABOUT FLYING WITH YOUR CHILD?

____
____
____
____

BEHAVIORAL INFORMATION:

WHAT ARE YOUR CHILD'S FEARS?____
____
____

- DOES YOUR CHILD HAVE ANXIEY ABOUT FLYING?____________

*HOW DOES YOUR CHILD BEHAVE WHEN ANXIOUS OR UPSET?

____
____
____

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WOULD YOUR CHILD BENEFIT FROM VISITING THE PLANE/ AIRPORT IN ADVANCE?_____________

IS YOUR CHILD AN "ESCAPE ARTIST" / RUNNER?________

DOES YOUR CHILD HAVE AGGRESSIVE BEHAVIORS? _________

- *IF YES, DESCRIBE:____
  ____
  ____
  ____

DOES YOUR CHILD HAVE SELF-INJURIOUS BEHAVIORS? _______________________

- *IF YES, DESCRIBE:____
  ____
  ____
  ____
  ____
  ____
  ____

*WHAT THINGS ARE CALMING TO YOUR CHILD?______________________________
____
____
____

IS YOUR CHILD VERBAL? ___________

- IF YES:
  - CONVERSATIONAL? __________
  - ABLE TO EXPRESS WANTS/ NEEDS? _______

DOES CHILD USE AUGMENTATIVE DEVICE TO COMMUNICATE?_________________

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DOES CHILD OR FAMILY MEMBER HAVE CLAUSTROPHOBIA OR FEAR OF SMALL SPACES? _______________

DOES CHILD OR FAMILY MEMBER HAVE EAR PROBLEMS?_________________

PLEASE LIST ANY MEDICAL PROBLEMS WITH FAMILY MEMBERS WHO WILL BE ACCOMPANYING CHILD?____

____

____

____

ATTACHMENTS:

PLEASE ATTACH A LETTER FROM LOCAL MD DOCUMENTING MEDICAL DISORDER OF CHILD.

PLEASE ATTACH A LETTER FROM DIRECTOR / BEHAVIORALIST / EARLY INTERVENTION PROVIDER OR SPECIAL ED TEACHER AT SCHOOL EXPLAINING CHILDS LEVEL OF DISABILITY AND WHY THIS MEDICAL VISIT WOULD BE HELPFUL TO CHILD/ FAMILY.

PLEASE FEEL FREE TO INCLUDE ANY ADDITIONAL PAGES IN REPONSE TO THE QUESTIONS ABOVE