



AUTISM ESCAPES FAMILY APPLICATION

BIOGRAPHICAL INFORMATION:

NAME OF CHILD: _____

HOME ADDRESS: _____

AGE OF CHILD: _____

WEIGHT: _____

HEIGHT: _____

CHILD'S 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? _____



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- 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 REPOSE TO THE QUESTIONS ABOVE***