Summer Program for the Education of Autistic Kids

S.P.E.A.K.
795 Pine Valley Drive
Suite 22
Pittsburgh, PA 15239
412-856-7223
SPEAK@autismpittsburgh.org

S.P.E.A.K. DATES FOR 2025

June 30	**First student day, full day**
July 1-2	In session
July 3-4	NOT in session
July 7-11	In session
July 14-18	In session
July 21-25	In session
July 28	In session
July 29	**Last day – half day for students**

Student Hours	9 a.m. to 2 p.m.
Staff Hours	8:15 a.m. to 2:15 p.m.
Location:	Saint Therese of Lisieux School 3 St. Therese Court Munhall, PA 15120

Summer Program for the Education of Autistic Kids

2025 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** _____

IMPORTANT: PLEASE NOTE NEW ADDRESS

T-Shirt Size: _____

RETURN BY MAY 31, 2025 TO:

Suite 22
Pittsburgh, PA 15239
SPEAK@autismpittsburgh.org
Provider of Services for Autism Involved Individuals in the Greater Pittsburgh Area

AUTISM PITTSBURGH

798 Pine Valley Drive

Summer Program for the Education of Autistic Kids

S.P.E.A.K.
795 Pine Valley Drive
Suite 22
Pittsburgh, PA 15239
412-856-7223
SPEAK@autismpittsburgh.org

2025 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'sName_____

_ 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, 2025

Year 2025

Summer Program for the Education of Autistic Kids

S.P.E.A.K.
795 Pine Valley Drive
Suite 22
Pittsburgh, PA 15239
412-856-7223
SPEAK@autismpittsburgh.org

AUTISM PITTSBURGH

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)_____

Year 2025

S.P.E.A.K.

Summer Program for the Education of Autistic Kids

S.P.E.A.K.
795 Pine Valley Drive
Suite 22
Pittsburgh, PA 15239
412-856-7223
SPEAK@autismpittsburgh.org

AUTISM PITTSBURGH

Return by: MAY 31, 2025

2025 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 ________________________________

2025 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 ________________________________

Year 2025

Summer Program for the Education of Autistic Kids

S.P.E.A.K.
795 Pine Valley Drive
Suite 22
Pittsburgh, PA 15239
412-856-7223
SPEAK@autismpittsburgh.org

AUTISM PITTSBURGH

Return by: MAY 31, 2025

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 _____

Year 2025

Summer Program for the Education of Autistic Kids

S.P.E.A.K.
795 Pine Valley Drive
Suite 22
Pittsburgh, PA 15239
412-856-7223
SPEAK@autismpittsburgh.org

AUTISM PITTSBURGH

*Return by MAY **31**, 2025*

CHILD HEALTH STATUS FORM 2025
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** _____