HOPE autism and Behavioral health services, LLC

Child's Name: _____Date of Birth: _____

Diagnosis (If Applicable): _____

Siblings (and Diagnosis if Applicable): _____

_____

Pertinent Medical Conditions: _____

Does your child have any medical conditions that could warrant an emergency plan? _____
(seizures, migraines, fall risk, choking hazard, pica, allergies requiring Epi Pen etc.)

If yes: An emergency plan has been submitted and reviewed by HOPE staff on _____
Date

Staff Signature: _____Staff Name: _____

Does your child have any medication that will be sent with them to the Center? _____

Medication Name: _____Location of Medication: _____

Type of Medication: Routine / As Need (with parent/guardian contact / Emergency

If non-routine medication is given, parent/guardian will be notified immediately

Staff Signature: _____Staff Name: _____

Known Allergies/Dietary Restrictions: _____

Mother/Guardian #1 _____

Home Number: _____ Work Number: _____ Cell Number: _____

Father/Guardian #2 _____

Home Number: _____ Work Number: _____ Cell Number: _____

Emergency Contact (in case parents can't be reached): _____

Home Number: _____ Work Number: _____ Cell Number: _____

List names of anyone other than parents who has permission to pick up your child (we will check ID of anyone other than parents requesting permission to take your child): _____

_____

Parent Signature: _____ Date: _____

7105 Crossroads Blvd Suite 106 ★ Brentwood, TN 37027★ 615-426-8393 ★ Hunter@HopeTN.com