



ACE

AUTISM CENTRE FOR EXCELLENCE

Student Admission Form

Please fill up all the fields to help us understand your child better

Form No. (For Office Use only) _____

Date of Application _____

Child's Information		
Child's Name (include middle name):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Contact Address:		Date of Birth: ___/___/_____
		Citizenship:
Weight:	Height:	Place of Birth:
Primary Language of Child:		Primary Language at Home:
Identifying Marks:		

Medical Information	
Diagnosis by: [*] (Name of Doctor and Clinic/Hospital)	
Primary Diagnosis:	
Secondary Diagnosis:	
Date of Diagnosis:	Medical Conditions:

* Please attach a copy of your child's diagnosis (if available). It should be from a Govt hospital/Psychologist

Parent's Information - Mother				
Name:		Maiden Name:		
Date of Birth:		Place of Birth:		
Address:		Email:		
		Mobile:		
Home Phone:		Highest Level of Education Completed:		
Occupation:		Name of Organisation:		Designation:
Current Work Address:		Work Phone:		
		Work Email:		
No. of Years with Present Organisation:		Previous Employer:		
Monthly Income (please circle)	INR 50,000 - 1,00,000	INR 1,00,000 - 3,00,000	INR 3,00,000 - 5,00,000	ABOVE INR 5,00,000

Parent's Information - Father				
Name:				
Date of Birth:		Place of Birth:		
Address:		Email:		
		Mobile:		
Home Phone:		Highest Level of Education Completed:		
Occupation:		Name of Organisation:		Designation:
Current Work Address:		Work Phone:		
		Work Email:		
No. of Years with Present Organisation:		Previous Employer:		
Monthly Income (please circle)	INR 50,000 - 1,00,000	INR 1,00,000 - 3,00,000	INR 3,00,000 - 5,00,000	ABOVE INR 5,00,000

Who will be the Primary Contact (Please circle the appropriate option)		
Mother	Father	Other (please specify)
Other (please specify):		

Custody Information - Parents' Marital Status (Please circle the appropriate option)		
Married	Separated	Divorced
Single	Widowe(r)	Unmarried
Other (please specify):		
Persons (s) assigned legal custody:		
Persons (s) assigned physical custody:		

Family Information - Siblings					
Name	Age	Sex	Date of Birth	Address	Phone
1.					
2.					
3.					

Health Information
<p>List any serious illnesses and/or hospitalizations:</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p>

Medication Information - Current Medication(s)		
Medication Name	Date Started	Purpose

Past Medication(s) - attach additional page if needed		
Medication Name	Date Started	Purpose

Additional Medical Information	
<p>Has your child been given all the required vaccinations? (If yes, please attach a copy of immunization record)</p> <p>-----</p> <p>-----</p> <p>-----</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Does your child have food/environmental allergies? (If yes, please list)</p> <p>-----</p> <p>-----</p> <p>-----</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Medical Information	
Does your child have drug allergies? (If yes, please list)	<input type="checkbox"/> Yes <input type="checkbox"/> No
.....	
.....	
.....	
Does your child have constraints for physical activities? (If yes, please list)	<input type="checkbox"/> Yes <input type="checkbox"/> No
.....	
.....	
.....	
Is your child on a special/restricted diet? (If yes, please provide details)	<input type="checkbox"/> Yes <input type="checkbox"/> No
.....	
.....	
.....	
Is eating or diet a problem for your child? (If yes, please explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No
.....	
.....	
.....	

Does your child have problems with (circle all / any that apply)		
Chewing	Swallowing	Choking
Refusal to eat	Excessive intake	Ingesting non-food items
Does your child have health needs that ACE needs to be aware of?		
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.....		
.....		
.....		

Sleep Habits	
Does your child sleep through the night? (If no, please describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No
----- ----- -----	
Any special bedtime routine? (If yes, please describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No
----- ----- -----	
Does your child typically nap during the day? (if yes, for how long?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
----- ----- -----	

General Information				
Is your child toilet trained? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child able to dress on his/her own? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is your child able to brush teeth on his/her own? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child able to bathe on his/her own? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How does your child communicate? (Circle all/any that apply)				
Verbal	Signs	PECS	Gestures	Other
What are your child's favourite food?				
----- ----- -----				
Which types of activities does your child enjoy doing with you at home?				
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How do you communicate most effectively with your child?

Swimming Proficiency (Circle any that apply or leave blank if unknown)

Independent	Shallow water only	Life belt/jacket	1:1 Required
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Educational Information

Details of Current Learning Centre / Therapy / School attended by your child

Name & Address:	Phone Number:
	Contact Person:

What are your top priorities from ACE's programme?
(List any three)

What special education services / early intervention services has your child recieved so far?

Speech Therapy	Occupational Therapy
Physical Therapy	Special Education/Intervention

Please list previous educational programme/therapy attended by your child

Programme/School	Date(s)	Reason for Change

Additional Information

Is there anything else you would like us to know about your child?

How did you learn about ACE?

Do you require a school bus facility for your child?

Yes

No

Limited number of scholarships available on the fulfillment of certain criteria.
Please let us know if you are interested in sponsoring another child's education.
For more information, please contact us at ACE@ACE-INDIA.ORG