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):			Gender: ☐ Male ☐ Female
Contact Address:			Date of Birth: __/__/____
			Age:
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	Gender	Date of Birth	Address	Phone
1.					
2.					
3.					

Health Information

List any serious illnesses and/or hospitalizations:

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

Has your child been given all the required vaccinations?
(If yes, please attach a copy of immunization record) ☐ Yes ☐ No

Does your child have food/environmental allergies?
(If yes, please list) ☐ Yes ☐ No

Additional Medical Information

Does your child have drug allergies? ☐ Yes ☐ No
(If yes, please list)

Does your child have constraints for physical activities? ☐ Yes ☐ No
(If yes, please list)

Is your child on a special/restricted diet? ☐ Yes ☐ No
(If yes, please provide details)

Is eating or diet a problem for your child? ☐ Yes ☐ No
(If yes, please explain)

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?

Sleep Habits

Does your child sleep through the night? ☐ Yes ☐ No
(If no, please describe)

Any special bedtime routine? ☐ Yes ☐ No
(If yes, please describe)

Does your child typically nap during the day? ☐ Yes ☐ No
(if yes, for how long?)

General Information

Is your child toilet trained? ☐ Yes ☐ No	Is your child able to dress on his/her own? ☐ Yes ☐ No
Is your child able to brush teeth on his/her own? ☐ Yes ☐ No	Is your child able to bathe on his/her own? ☐ Yes ☐ 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?

How do you communicate most effectively with your child?

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 received 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?

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**