



Solutions for Children and Families, LLC
Building Skills For Successful Peer Relationships

Social Bridges Registration Form

Child's Name: _____ Date of Birth: _____

Home Address: _____

Mother's Name: _____ Home Phone: _____

Cell Phone: _____ E-Mail: _____

Father's Name: _____ Home Phone: _____

Cell Phone: _____ E-Mail: _____

Siblings (list names & ages): _____

Name of School: _____ Phone: _____

Teacher's Name: _____ Grade: _____

Does your child participate in any ESE (Exceptional Student Education) programs? If yes, please specify: (gifted, learning disabilities, etc.) _____

Diagnosis (if applicable): _____

Allergies (medications, food, etc.): _____

Please list all support services child is receiving: (speech/language, occupational therapy, psychotherapy, etc.):

Support Services:	Name of Therapist:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child take any medications? If so, please list: _____

Is there any reason your child should not participate in certain activities? If so, please describe:

Does your child have any medical conditions/concerns? _____ If yes, please describe:

Please check all areas of concern that affect your child's social success:

- | | | |
|--|--|--|
| <input type="checkbox"/> Behaving impulsively | <input type="checkbox"/> Exhibiting anxiety | <input type="checkbox"/> Having temper tantrums |
| <input type="checkbox"/> Lacking eye contact | <input type="checkbox"/> Exhibiting non-compliance | <input type="checkbox"/> Displaying separation anxiety |
| <input type="checkbox"/> Adapting to new situations | <input type="checkbox"/> Taking turns | <input type="checkbox"/> Interrupting conversations |
| <input type="checkbox"/> Using a soft voice | <input type="checkbox"/> Reading facial expressions | <input type="checkbox"/> Understanding social cues |
| <input type="checkbox"/> Exhibiting bullying behavior | <input type="checkbox"/> Receiving bullying behavior | <input type="checkbox"/> Listening to others |
| <input type="checkbox"/> Contributing (off topic) to conversations | <input type="checkbox"/> Exhibiting hurtful behaviors (towards self, others) | |
| <input type="checkbox"/> Initiating/maintaining conversations | <input type="checkbox"/> Other (please explain): | |

To help us better understand your child's needs; please describe your child in the following areas:

Socialization: _____

Following/understanding directions: _____

Peer interaction skills: _____

Response to frustration: _____

Temperament: _____

What are your goals for your child in participating in Social Bridges? _____

Please feel free to use this space to provide us with any information that you have not yet shared that would be beneficial in helping us to provide a successful social skills experience for your child.

Signature

Date

Please complete this form, sign and return to:

Solutions for Children and Families, LLC
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