The Aspen Center Registration Form (19-20)

Child's Name: _____ **DOB:** _____
Parent's Name: _____
Address: _____
Phone Numbers:Day _____ **Evening** _____
Email Address: _____
Authorized Pick UpNames: 1. _____
2. _____
3. _____
Allergies _____
Medications** _____
Medical Information: _____
Physician's Name: _____
Immunization Record: _____
****Aspen Center Staff will not administer any medications**
Evaluation Date: _____ **Where?** _____
Communication Disorder Diagnosis (if any) _____
Individual Therapist's name and phone # _____

I give permission to Aspen Center to contact individual therapists working with my child and share pertinent information regarding care and treatment plan.
Parent Signature:_____

I give permission for Aspen Center to photograph my child for use in individual and group therapy activities.
Parent Signature:_____

I give permission for Aspen Center to use photographs and videos of my child for use in media, website and education/presentations.
Parent Signature:_____

I understand and will abide by the written 30 day withdrawal policy.
Parent Signature:_____

Aspen Center Payment Information

There is a one month Registration Fee due at time of registration. This fee coverers start up costs as well as the evaluation process for each child at the beginning of a school year.

Child's Name: _____
Parent Name (on billing information) _____

Program Runs 8:30-12:00

__The Grove (ages 3-6) _____4 day/week ($520) _____ 5day/week ($620)
__Sprouts (ages 3-4) _____4 day/week ($520) _____ 5day/week ($620)
__Seedlings (ages 18 months-3 yrs)
_____ 2 Day Program ____M/W ____T/TH $320/month
_____ 4 Day Program $520/month

- **5% discount for tuition paid in full for the school year**
- **10% discount for siblings**
- **$100 discount per month for typically developing students.**

Lunch Bunch:
Lunch bunch is available for an additional cost for a limited number of children each day from 12-12:30. Please check availability with staff if you are interested.

Individual therapy services are available from The Aspen Center during and before/after class, for additional costs. Individual therapy can be filed with insurance and will be billed separately. Therapy payments cannot be included in any tuition payments for invoicing purposes.

Payment Options:
_____Cash
_____Check **Checks made out to Aspen Center
_____Visa/MC Card Number_____
Expiration Date_____ Security number (3 digit # in back)_____
Billing Address: _____
_____

For Office use:

Registration Fee Received:_____Date: _____

First Month Received:_____Date:_____

1/19

Aspen Center Parent Questionnaire

What do you hope your child will gain by attending Aspen?

Please list activities your child enjoys.

Please list activities your child does not enjoy.

What are your child's greatest strengths?

Are there any areas in which you would like to see your child develop more fully?

Has your child participated in playgroups; been to birthday parties, attended classes, school or camps before? If so, please describe your child in the group dynamic.

Do you have any safety concerns regarding your child?

Does your child have limited communication skills? If so, please describe.

If your child has limited words or uses sign language please list the words and signs currently being used.

Does your child receive any specialized therapy services?

Does your child have any diagnosis, medical issues or other concerns that we need to be aware of?

Hospital Preference_____ Physician_____ Phone_____