SCHIEFELBUSCH
Speech-Language-Hearing Clinic

Schiefelbusch-Sertoma Summer Program

AAC Teen Connections

Please complete and return this form to the Schiefelbusch Clinic at your earliest convenience. Space is limited. Program fees are $200 per child, minus $100 SERTOMA Scholarship. **The total family cost is $100 per child.** Questions may be directed to Sarah Domingos by email at sdomingos@ku.edu or phone at (785) 864-4690.

Participant Information

Child Name _____ Pronouns _____

Date of Birth _____

Parent/Guardian Name(s) _____

Street Address _____

City _____ State _____ Zip _____

E-Mail _____ Cell Phone _____

License Plate State and Number _____

Ages 12 - 17

June 23rd - 27th — Monday thru Friday

9:00 a - 12:00 p

KU SCHIEFELBUSCH Speech-Language-Hearing Clinic

SERVICE TO MANKIND · SERTOMA · SINCE 1912

Please help us serve each participant the best we possibly can by answering the following questions regarding your child.

In what ways does the individual express themselves? (Verbal, speech-generating device, signs/gestures, other?)

What kind of AAC device and software does the individual use?

Describe 1-2 things you/the individual would like us to focus on during the group sessions. What would you like to gain from this group experience?

Describe any sensory and/or behavioral needs that would be helpful for us to know about and how we can best support the individual.

Describe any physical, health, or medical information that would be important for us to know (e.g., allergies, medications, physical needs)

Describe some of the individual's interests and anything they do not like:

If your child has an IFSP or IEP that would help us in supporting them, please send via email to sdomingos@ku.edu or fax to (785)864-5094. Please note, sending private information via email is not HIPPA-compliant.

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In case of emergency, contact: _____ at: _____

Consent for taking and use of pictures and videos:

I give my permission for photographs and videos to be taken of our child during summer program activities for publication, education, or other media use related to the promotion and operation of the summer program and educational use at the University of Kansas.

_____ _____

Parent or Legal Guardian Signature **Date**

Authorization for Emergency Medical Care:

I give my permission to Sertoma-Schiefelbusch Summer Program staff to call emergency medical service and for the medical service to provide emergency medical care for my child _____, should a medical emergency arise. It is understood that staff will make a conscientious effort to locate parents and/or emergency contacts listed on this form before any action is taken. I/We will accept the expense of medical treatment.

_____ _____

Parent or Legal Guardian Signature **Date**

Authorization to Pick-Up Child

Permission is hereby granted to SERTOMA-Schiefelbusch Summer Program staff to release the above-named child to the following persons, provided proper identification is first established. PLEASE LIST THE NAMES OF ALL AUTHORIZED PERSONS AND THEIR RELATIONSHIP TO THE CHILD, INCLUDING YOURSELF AND ANY OTHER PARENT/LEGAL GUARDIAN.

1. _____ Relationship _____ Telephone # _____
2. _____ Relationship _____ Telephone # _____
3. _____ Relationship _____ Telephone # _____
4. _____ Relationship _____ Telephone # _____

Please return original form to:
Schiefelbusch Clinic
1200 Sunnyside Ave. 2101 Haworth Hall
Lawrence, KS, 66045
sdomingos@ku.edu
(785) 864-5094 (fax)