

# Drama Therapy Registration



Child's Name \_\_\_\_\_ Child's Age \_\_\_\_\_

Parent Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Child's Gender:  M  F

What is your child's diagnosis:

- Autism  PDD  PDD-NOS  HFA  
 Asperger Syndrome  Neurotypical

My child is verbal:  Yes  No

Does your child have any sensory issues that may be a problem? If yes, please describe: \_\_\_\_\_

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Please explain your child's academic environment (regular, private, home school, cyber school, regular ed w/aide, etc.):

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How do you see this program benefiting your child? \_\_\_\_\_

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I plan to bring a TSS on a regular basis:  Yes  No

Does your child typically need individual attention, or will he or she be able and/or willing to participate in a group setting?

Explain: \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

Does your child have any allergies? If so, please list: \_\_\_\_\_

\_\_\_\_\_

Does your child tend to wander or run away?  Yes  No

Additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MAIL TO:

AUTISM CENTER OF PITTSBURGH  
135 CUMBERLAND RD.  
SUITE 105  
PITTSBURGH, PA 15237

CLASSES BEGIN SEPTEMBER 12