



Westcoast Child Development Group Inc.

CLUB CONNECTS

Therapeutic Social Skills Groups for Children and Youth

Registration Form

General Information

Child/Youth Name _____
Last First

Date of Birth ____/____/____ Age _____ Male Female
Day Month Year

Parents/Guardians _____
1. Name in full and relationship 2. Name in full and relationship

Family Address _____
Street and number City Postal Code

Home Phone _____ Work Phone _____

Cell/Pager _____ Email _____

Clinical Information

Referring Source _____

Most Recent Diagnosis

- High-functioning Autism
 Asperger's Syndrome
 Pervasive Developmental Disorder-NOS (Not otherwise specified)

Additional Diagnoses?

203-3195 Granville St.
Vancouver, BC, V6H 3K2
Club Connects Intake Ph: 604-732-3222
Club Connects Fax: 604-732-3232

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General Health Information

Allergies _____

Medications 1. _____

2. _____

Emergency Contacts

1. _____
Name Relationship phone during day/evening

2. _____
Name Relationship phone during day/evening

Social/Emotional Information

What are your child's two main interests?

1. _____

2. _____

What are your child's main dislikes?

What do you see as your child's strengths?

Thank you for taking the time to complete this application form. If you have additional information that you feel is applicable to your child's group experience please feel free to include it with this application form. Please mail or fax this to us as soon as possible, so that we can process all the information in a timely manner. If you have any questions about this form or the group process, please contact us:

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