



Sibling Program in Partnership with PALs and Grant a Gift Autism Foundation
Enrollment Form

Please Fax Completed Form to 702-564-2453

Sibling Information

Name _____ Age _____ Grade _____ Circle one: Elem Middle High

Address _____ Phone _____

Email _____ Referred By _____

Brother or Sister's (Natural/Marriage/Foster/Adoption) Medical/IEP Diagnosis: _____

Brother or Sister's Age: _____

Parent Information

Mother's Name _____ Address _____

Phone Number _____ Work Number _____

Cell Number _____ Email Address _____

Father's Name _____ Address _____

Phone Number _____ Work Number _____

Cell Number _____ Email Address _____

Authorized Escorts or Persons Authorized to Call in an Emergency

Name_____	Phone_____
Address_____	Relationship_____
Name_____	Phone_____
Address_____	Relationship_____

There is no fee for the clinical workshops, however there may be a small fee to cover the overall cost of various social outings which will be determined based on the activity. Please contact Lynda Tache at info@grantagiftautismfoundation.org for additional info.

I approve of enrolling my child in the sibling workshop program through PALS Learning Center in partnership with Grant a Gift Autism Foundation. I authorize Grant a Gift Foundation to verify any and all information provided. I also state that all information provided on the application and during interview process is accurate and true to my knowledge. I also understand that any false or misleading information given will automatically disqualify me from any current or future participation and/or funding for other services.

Print name: _____
Mother of Child

Signature: _____
Mother of Child

Date: _____

Print name: _____
Father of Child

Signature: _____
Father of Child

Date: _____