Preschool for Children with Autism
at the Vanderbilt Bill Wilkerson Center

Medical Center East, South Tower
1215 21st Avenue South, Suite 6209
Nashville, Tenn. 37232-8718
Phone: (615) 936-5212
Fax: (615) 875-1411

MR#:_____

ENROLLMENT INFORMATION

PLEASE PRINT

Child's Name _____Date of Birth_____

Home Address (**no P.O. Box**)_____

City_____State_____Zip Code_____

Home Telephone Number_____Sex M F

Father's/Guardian's Name_____

Address (if different than above)_____

City_____State_____Zip Code_____

Business Phone_____Cell Phone _____Pager_____

Email Address_____

Father's/Guardian's Current Job or Occupation_____

Highest Education Level (please check the box):

- ☐ did not complete high school
- ☐ completed high school
- ☐ attended technical/vocational school
- ☐ attended some college
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Professional doctorate degree (MD, JD)
- ☐ PhD or EdD

Mother's/Guardian's Name_____

Address (if different than above)_____

City_____State_____Zip Code_____

Business Phone_____Cell Phone _____Pager_____

Email Address_____

Mother's/Guardian's Occupation_____

Highest Education Level (please check the box):

☐ did not complete high school
☐ completed high school
☐ attended technical/vocational school
☐ attended some college
☐ Bachelor's degree
☐ Master's degree
☐ Professional doctorate degree (MD, JD)
☐ PhD or EdD

Parents living together? ☐ YES ☐ NO

If no, who has legal custody?_____

(Please supply legal papers with your registration form)

Does the child have any siblings? ☐ YES ☐ NO

If yes, please list their names and ages _____

_____

What is the primary language spoken at home?_____

Do you consider your child Hispanic or Latino? ☐ YES ☐ NO

What is your child's race? Please check one or more categories

☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Other _____

Name of Child's Physician_____

Address _____

City_____State_____Zip Code_____

Telephone Number_____

Additional Services

Does your child currently receive other services (e.g., Occupational Therapy, Feeding Therapy, ABA Therapy, etc.)? If so, which services?

_____

Special Needs

In addition to the diagnosis of Autism, does your child have any other special needs?

☐ YES ☐ NO

If yes, please explain_____

Does your child have any special health concerns? ☐ YES ☐ NO

If yes, please explain _____

_____

Does your child have any dietary restrictions? ☐ YES ☐ NO

If yes, please explain _____

_____

Is your child on medication? ☐ YES ☐ NO

If yes, please list medication(s) and dosage _____

_____

Insurance Information

Primary Health Insurance Co._____ID#_____

Name of Policy Holder_____Group#_____

Address _____

City_____State_____Zip Code_____

Telephone Number_____

Secondary Health Insurance Co._____ID#_____

Name of Policy Holder_____Group#_____

Address _____

City_____State_____Zip Code_____

Telephone Number_____

Emergency Contact Information/Who can your child be released to:

Name _____ Relationship _____

Phone Number (____)_____

Name _____ Relationship _____

Phone Number (____)_____

Name _____ Relationship _____

Phone Number (____)_____

How did you learn about our Program:_____

Parent/Guardian Signature_____Date_____