CELECTS EDUCATION LLC

2708 FLEETWOOD DR, FLORENCE, SC 29505

PHONE: [redacted] (843)731-9017

APPLICATION FOR CELECTS EDUCATION ABA PROGRAM

OR

APPLICATION FOR CELECTS EDUCATION K-12 SCHOOL

(CIRCLE ONE PLEASE)

PARTICIPANT INFORMATION:

NAME: _____

AGE: _____CURRENT GRADE (24/25 SCHOOL YEAR) _____

DATE OF BIRTH: _____ GENDER: MALE ( ) FEMALE ( )

****

PARENT/GUARDIAN INFORMATION:

NAME: _____

RELATIONSHIP TO CHILD/CHILDREN: _____

EMAIL: _____

PHONE NUMBER: _____

ALTERNATE PHONE NUMBER: _____

****

SECONDARY PARENT/GUARDIAN INFORMATION

NAME: _____

RELATIONSHIP TO CHILD/CHILDREN: _____

EMAIL: _____

PHONE NUMBER: _____

ALTERNATE PHONE NUMBER: _____

****

EMERGENCY CONTACT INFORMATION (PLEASE LIST IN ORDER THAT YOU WANT US TO CALL)

NAME: _____

RELATIONSHIP TO CHILD/CHILDREN: _____

PHONE NUMBER: _____

****

SECONDARY EMERGENCY CONTACT INFORMATION

NAME: _____

RELATIONSHIP TO CHILD/CHILDREN: _____

PHONE NUMBER: _____

****

MEDICAL INFORMATION

ALLERGIES: _____

SPECIAL DIETARY NEEDS: _____

CURRENT MEDICATIONS: _____

OTHER MEDICAL CONDITIONS:

_____

_____

_____

****

WHO HAS PERMISSION TO PICK UP YOUR CHILD/CHILDREN (ONLY THOSE ON THIS LIST WILL BE ALLOWED TO PICK UP YOUR CHILD/CHILDREN)

NAME: PHONE: ADDRESS: EMAIL:

1. _____

2. _____

3. _____

4. _____

(ONLY FILL OUT IF YOU'RE APPLYING FOR SCHOOL)

IS YOUR CHILD UP TO DATE ON CURRENT IMMUNIZATIONS? ☐ YES ☐ NO

IF YES PLEASE PROVIDE A COPY. IF NO PLEASE LIST REASON WHY.

_____

_____

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IF APPLYING FOR ABA PROGRAM PLEASE FILL OUT THE FOLLOWING AND ATTACH A COPY OF INSURANCE CARDS

FIRST NAME: _____ LAST NAME: _____

MIDDLE INITIAL_____

PREFERRED NAME: _____

PATIENT IS: ☐ POLICY HOLDER ☐ RESPONSIBLE PARTY

(RESPONSIBLE PARTY IF SOMEONE OTHER THAN THE PATIENT)

FIRST NAME: _____ LAST NAME: _____

MIDDLE INITIAL_____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EXT:_____

BIRTH DATE: _____ SOCIAL SECURITY NUMBER: _____

DRIVERS LICENSE: _____ STATE:_____

☐ RESPONSIBLE PARTY IS ALSO A POLICY HOLDER FOR PATIENT

☐ PRIMARY INSURANCE POLICY HOLDER ☐ SECONDARY INSURANCE POLICY HOLDER

PATIENT INFORMATION

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EXT: _____

SEX: ☐ MALE ☐ FEMALE

BIRTH DATE: _____ AGE:_____ SOCIAL SECURITY NUMBER: _____

DRIVERS LICENSE: _____ STATE:_____

****

****SECTION 2****

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ N/A

STUDENT STATUS: ☐ FULL TIME ☐ PART TIME

MEDICAID ID: _____

EMPLOYER ID: _____

CARRIER ID: _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: _____

INSURED SSN: _____ INSURED DOB: _____

EMPLOYER: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED: _____

RELATIONSHIP TO INSURED: _____

INSURED SSN: _____ INSURED DOB: _____

EMPLOYER: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

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MEDICAL CONSENT FORM

STUDENT NAME: _____

ARE YOU THE LEGAL GUARDIAN FOR THIS STUDENT? ☐ YES ☐ NO

I HEREBY GIVE MY CONSENT FOR THE FOLLOWING INDIVIDUALS TO BRING MY CHILD/CHILDREN TO:

CELECTS EDUCATION ABA

FOR TREATMENT IN MY ABSCENCE. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL I AUTHORIZE CANCELLATION BY HAVING THIS CONSENT FORM REMOVED FROM THE CHART.

SIGNED: _____

PRINTED NAME: _____

WITNESS: _____

Date: _____

BELOW ARE THE NAMES, RELATIONSHIPS, AND TELEPHONE CONTACT NUMBERS OF WHOM MAY ACCOMPANY MY CHILD/CHILDREN TO CELECTS EDUCATION ABA

NAME:	RELATIONSHIP:	PHONE NUMBER:

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END OF FORM