



Autism Assistance Dog Application

Highland Canine Training, LLC
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Harmony, NC 28634
www.highlandcanine.com
704.500.8281

Parent/Guardian Information

Name _____
Street Address _____
City _____ State _____ Zip _____
Home phone (___) _____ - _____ Cell (___) _____ - _____ Other (___) _____ - _____
Email Address _____
Preferred method of contact _____

Name _____
Street Address _____
City _____ State _____ Zip _____
Home phone (___) _____ - _____ Cell (___) _____ - _____ Other (___) _____ - _____
Email Address _____
Preferred method of contact _____

Child Information

Name _____ Sex _____
Date of Birth _____ Birth Order _____
Height _____' _____" Weight _____ lbs.

School Name _____
Street Address _____
City _____ State _____ Zip _____
Office phone (___) _____ - _____ County _____ District _____
How many hours per week is your child in school? _____

Doctor Name _____
Office Name (if applicable) _____
Street Address _____
City _____ State _____ Zip _____ Office phone (___) _____ - _____

Primary Diagnosis _____

Age at Time of Diagnosis _____

Secondary Diagnosis _____

Please describe the most significant symptoms of the illness and how it affects the child:

What types of therapies is the child currently involved in (including special programs at school)?

How many hours per week is your child in therapies? _____

List medications, dosage and frequency:

With whom does the child live? _____

We currently reside in a

Your residence currently has

Other children in home:

Name	Sex	Date of Birth

Do you have any current pets?

Species	Breed	Name	Age	Sex

Is anyone in your home allergic to dogs or pet dander?

Please indicate any of the following conditions that may apply. Describe behaviors, if necessary.

0 = Not Applicable, 1 = mild, 10 = severe

Seizures

Panic Attacks

Violence to Self

Violence to Others

Violence to Property

Mood Swings

Hallucinations

Nightmares

Night Awakenings

Racing Thoughts

Medication Side Effects

Distractibility

Suicidal Behaviors

Self-stimulating Behaviors

Disassociation

Impulsivity

Poor Judgment

Self-care Deficits

Difficulty Managing Environment

Difficulty Completing Tasks

Child Bolts, Runs, or Wanders Away

Please describe any of the behaviors or conditions listed above, if necessary.

How do you see a service dog helping your child?

Have you previously owned a service or assistance dog?

Have you ever owned a dog in the past?

Who was responsible for the dog's training?

Are you willing to participate in ongoing training sessions after receiving a service dog?

Will your family accept a trained dog as an equal partner in your house?

In order to keep the service dog's training sharp, the trainers will need to train adults in the family to keep up the training. Who will be responsible for keeping up the training each week?

Do you see the dog going to school with your child?

If yes, who will be responsible for handling the dog at school?

Please include any additional information that may be important for us to know.

The information on this application is correct to the best of my knowledge. I understand that this preliminary application is required to be eligible for a packet application which will determine my suitability for a service dog. _____ (initials)

Applicant Signature _____ Date _____

Print Name _____ Relationship _____