Service Dog Application (Child)

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1) Parent/Guardian Information (Required to be completed fully)

Name ___________________________________ Parent/Guardian (please circle)
Street Address ____
City ____ State _____________ Zip _______________
Home phone (___) _____ - _______ Cell (___) _____ - _______ Other (___) _____ - _______
Email Address ____
Preferred method of contact ____

Name ___________________________________ Parent/Guardian (please circle)
Street Address ____
City ____ State _____________ Zip _______________
Home phone (___) _____ - _______ Cell (___) _____ - _______ Other (___) _____ - _______
Email Address ____
Preferred method of contact ____

2) Child Information (Required to be completed fully)

Name ____
Date of Birth _______________________________________ Sex - ☐ Male ☐ Female
Height ______'______" Weight _________ lbs.

School *(if applicable)* ____
Street Address ____
City ____ State _____________ Zip _______________
Office phone (___) ______ - ______ County __________________ District __________________
How many hours per week is your child in school? _______________________________________
Do you plan to have your child (or an aide) take the Service Dog to school with him/her?
☐ YES ☐ NO If yes, which one: Child or Aide

3) Medical Information (Required to be completed fully)

Doctor Name/Specialty____
Office Name (*if applicable*) ____
Street Address ____
City ____________________ State _____ Zip __________ Office phone (___) ______ - _______

Primary Diagnosis ____
Age at Time of Diagnosis _________________
Secondary/Tertiary Diagnosis ____
____

Please describe the most significant symptoms of your child's disability/illness and how it affects him/her (*attach separate sheet if necessary*):

____
____
____
____
____

Check any and all medical problems that apply to your child:

☐ Arthritis ☐ Fainting
☐ Asthma ☐ High Blood Pressure
☐ Alcohol or Drug Dependency ☐ Heart Disease
☐ Diabetes ☐ Visual Impairment
☐ Other ____

List any allergies (food, animals, material, etc.) ____
____
____

List medications (dosage and frequency): ____
____
____

Would any of your child's current medications impair their ability to manage a service dog or impact learning how to work with your dog? ☐ YES ☐ NO

If so, describe ____
____
____

Does your child have any cognitive difficulties (such as memory problems, inability to concentrate, etc.) that would affect their ability to manage a service dog? ☐ YES ☐ NO
If so, describe ____
____
____
Does your child have any visual difficulties (such as degraded peripheral vision, lack of vision in one eye, etc.) that would affect your ability to manage a service dog? ☐ YES ☐ NO
If so, describe ____
____
____

Does your child have any speech difficulties that would affect your ability to manage a service dog? ☐ YES ☐ NO
If so, describe ____
____
____

Does your child require the assistance of an aide or family member for daily living skills? ☐ YES ☐ NO If yes, list the responsibilities of each individual.

Name	Daily Hours	General Duties	Telephone

Are they willing to assist with the daily care of a service dog, if needed? ☐ YES ☐ NO

What types of therapies is your child currently involved in? ________________________________
____
____
____
How many hours per week is he/she in therapies? ____________________________________

Do you anticipate future surgery or hospitalization for any reason for your child? ☐ YES ☐ NO
If so, explain. ____

____

Has there been any life changing events that has happened in the last 6 month? ☐ YES ☐ NO
If yes, explain

____

____

Do you anticipate any life changing events in the next year? ☐ YES ☐ NO
If yes, explain

____

____

Are there any limitations of either parent/guardian that would hinder handling of a service dog (medical, job requirements, etc.)? ☐ YES ☐ NO
If yes, explain ____

____

a) Is your child diagnosed with Autism/Downs Syndrome (if no, go to next section)

Please indicate any of the following conditions that may apply.

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

Also please indicate how often they occur.

N=Never, AN=Almost never, M=Monthly, W=Weekly, D=Daily, S=Multiple times a day

												How often
Panic Attacks	0	1	2	3	4	5	6	7	8	9	10	________
Violence to your Self	0	1	2	3	4	5	6	7	8	9	10	________
Violence to Others	0	1	2	3	4	5	6	7	8	9	10	________
Violence to Property	0	1	2	3	4	5	6	7	8	9	10	________
Mood Swings	0	1	2	3	4	5	6	7	8	9	10	________
Hallucinations	0	1	2	3	4	5	6	7	8	9	10	________
Nightmares	0	1	2	3	4	5	6	7	8	9	10	________
Night Awakenings	0	1	2	3	4	5	6	7	8	9	10	________
Racing Thoughts	0	1	2	3	4	5	6	7	8	9	10	________
Medication Side Effects	0	1	2	3	4	5	6	7	8	9	10	________
Distractibility	0	1	2	3	4	5	6	7	8	9	10	________
Suicidal Behaviors	0	1	2	3	4	5	6	7	8	9	10	________
Self-stimulating Behaviors	0	1	2	3	4	5	6	7	8	9	10	________
Disassociation	0	1	2	3	4	5	6	7	8	9	10	________
Impulsivity	0	1	2	3	4	5	6	7	8	9	10	________
Poor Judgment	0	1	2	3	4	5	6	7	8	9	10	________

Self-care Deficits	0	1	2	3	4	5	6	7	8	9	10	________
Managing Environment	0	1	2	3	4	5	6	7	8	9	10	________
Difficulty Completing Tasks	0	1	2	3	4	5	6	7	8	9	10	________
Child Bolts or Wanders Away	0	1	2	3	4	5	6	7	8	9	10	________

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

____

____

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b) Does your child have mobility/stability issues (if no, go to next section)

Limited in mobility? ☐ YES ☐ NO

If so, how? ____

____

Does your child use a wheelchair? ☐ YES ☐ NO If yes: ☐ Electric type: __________ ☐ Manual

Does your child use any other mobility aides? ☐ YES ☐ NO

If so, what? ____

Will you want the service dog to help support them while they are walking or getting up?

☐ YES ☐ NO

If so, describe ____

____

Is one side of your child's body stronger than the other? ☐ YES ☐ NO

Which side ☐ Left ☐ Right

Is your child restricted in their use of your hands or arms? ☐ YES ☐ NO

If so, describe ____

____

On a scale of 1-5 (1 = poor, 5= excellent), describe your child's:

Upper body strength	1	2	3	4	5
Range of motion	1	2	3	4	5
Grip strength	1	2	3	4	5
Dexterity	1	2	3	4	5

Is your child able to issue hand signals? ☐ YES ☐ NO

Does your child have spasms in your arms or legs? ☐ YES ☐ NO

If so, how quickly do they pass? ____

Does your child bruise easily? ☐ YES ☐ NO

Could a dog put his front legs up on your child's lap without hurting them? ☐ YES ☐ NO

Is your child able to issue voice commands in a clear, audible voice? ☐ YES ☐ NO

c) Does your child experience seizures (if no, go to next section)

What type of seizures does your child have? _______________________________________

____

____

How often does seizure activity happen? ____

Describe what the seizures look like ____

____

Do you expect the dog to be trained for seizure alert and/or assistance? ___ Yes ___ No
If so, describe how you see the dog helping? ______________________________________

____

____

____

d) Is your child hard of hearing or have hearing loss (if no, go to next section)

Describe the extent of hearing loss (full, partial, both ears, one ear L/R, etc.)

____

____

Does your child use any hearing aids? Yes/No If Yes, which types ____________________

____

To what sounds would you like your dog to alert to? ______________________________

____

Is your child able to give verbal commands? Yes/No
Would you like your dog to be trained on verbal or hand signals? Verbal/Hand Signals

e) Does your child have psychiatric issues (if no, go to next section)

What are the triggers? ____

____

Are there any indications (either verbal or visual) that your child does before having a panic attack, anxiety, night terrors, etc. (e.g. rubbing thighs, scratching head, hyperventilating, etc.)? If yes, please describe ____

____

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Please indicate any of the following conditions that may apply.

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

Also please indicate how often the occur.

N=Never, AN=Almost never, M=Monthly, W=Weekly, D=Daily, S=Multiple times a day

												How often
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Difficulty Completing Tasks	0	1	2	3	4	5	6	7	8	9	10	________

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

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3) Lifestyle Information (Required to be completed fully)

We currently reside in a ☐ House ☐ Apartment ☐ Duplex ☐ Other __________________

Your residence currently has ☐ fenced yard ☐ enclosed area ☐ Other ___________________
With whom does your child live? ____
Other people in home:

Name	Sex	Date of Birth	Relationship

Do you have any current pets?

Species	Breed	Name	Age	Sex

Is anyone in your home allergic to dogs or pet dander? ☐ YES ☐ NO
If yes, Whom________________________

Where does your child currently sleep? ___________________________________
Where do you want your child to sleep? ______________________________
What size is your child's bed (King, Queen, etc.)? _________________
How high off the floor is your child's bed (in feet)? _______________
Where in the room will the Service dog be sleeping (in bed, on floor, in crate, etc.) ___________
Will the dog be allowed on the furniture/bed? Y/N
When do you get out of bed in the morning? ___________
What time do you retire? _________

What type of recreational activities do you and your child do and how often? ______________
____
____
____

Where do you and your child like to go out in public? __________________________________
____
____
____

Do you see yourself travelling a lot with your service dog? ☐ YES ☐ NO

What type of transportation do you see using (e.g. plane, car, bus, etc. please be specific with the frequency of each)____

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4) Service Dog Requirements (Required to be completed fully)

Who will be the primary handler of the service dog (does not have to be one person) ________

____

How do you see a service dog helping your child?

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____

Do you have a preference for a dog breed? ☐ YES ☐ NO

If yes, which breed/type (e.g., Hypoallergenic, Labrador, etc.) _____________________ and why? ____

Have you ever owned a dog in the past? ☐ YES ☐ NO

Who was responsible for the dog's training?

____

Have you previously owned a service or assistance dog? ☐ YES ☐ NO

If so, explain. ____

____

Do you have any experience working with animals? ☐ YES ☐ NO

If so, explain. ____

____

After receiving your service dog, what are your hopes, goals, and fears?

____

____

____

Where will the dog exercise and have playtime? ______________________________________

Where will the dog be taken for toilet requirements? ___________________________________
How much exercise, on average, do you think a dog needs per day? _______________________
Describe your definition of exercise. ____
____
Who will help you with the dog's care if you are sick and cannot get outside:
Name _____________________________________ Phone ______________________________
Proximity to your home ____

On which side would you want the dog to work most of the time? (If you are right-handed, it is common for the dog to be trained to work on your left so your right hand can be free from leash, etc.)
☐ Left ☐ Right
Why? ____

Do you have any concerns regarding owning a service dog? ☐ YES ☐ NO
If so, describe. ____
____

Are you willing to participate in ongoing training sessions after receiving a service dog?
☐ YES ☐ NO
Will your family or housemates accept a trained dog as an equal partner in your house?
☐ YES ☐ NO

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

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 ____