



Service Dog Application (Child)

Highland Canine Training, LLC

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Harmony, NC 28634

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704.500.8281

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:

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Alcohol or Drug Dependency | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> 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

	0	1	2	3	4	5	6	7	8	9	10	How often	Example: 3, W
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.

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:

<i>Upper body strength</i>	1	2	3	4	5
<i>Range of motion</i>	1	2	3	4	5
<i>Grip strength</i>	1	2	3	4	5
<i>Dexterity</i>	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 _____

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

	0	1	2	3	4	5	6	7	8	9	10	How often	Example 2, D
Panic Attacks	0	1	2	3	4	5	6	7	8	9	10	_____	
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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.

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) _____

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?

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.

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 _____