

Participant Name _____



SOCIAL SKILLS CLASSES APPLICATION Part 1

Todays' Date: ____/____/____

Name of Participant: _____

Goes By: _____ Age: _____ Date of Birth: _____

Diagnosis(s): _____

Address: _____

Email: _____

Participant's Phone: _____

Any allergies? _____

Diet restrictions? _____

Can the participant use the bathroom on his/her own? Y or N

Can they wipe themselves on their own? Y or N

If female, do they have their period yet? Y or N

Do they need assistance in the bathroom when they have their period. Y or No

If Yes, please explain: _____

Behaviors that we may see:

Guardian's Name: _____ Relationship: _____

Guardian's Phone: _____

Guardian's Email: _____

Do you have: _____ Power of Attorney _____ Guardianship Completed?

Participant Name _____



I have chosen the following weeks for 2025-2026:

Saturday Group 9am-12pm (check all)

_____ **Session 1 Classes: 9/6, 9/13, 9/20, 9/27, 10/4, 10/11, 10/18**

_____ **Session 2 Classes: 11/1, 11/8, 11/15, 11/22, 12/6, 12/13, 12/20**

_____ **Session 3 Classes: 1/10, 1/17, 1/24, 1/31, 2/7, 2/14, 2/21**

_____ **Session 4 Classes: 3/7, 3/14, 3/21, 4/4, 4/11, 4/18, 4/25**

Each Session (set of classes) is \$675, no prorations.

******All fees need to be paid prior to the first class in order to join the session (no later than Friday before the start of the class)***

_____ Total Sessions Chosen= \$_____

_____ Session Tuition + \$25 Application Fee = _____ Total Amount Owed

Social Skills Classes Application Fee:

I have enclosed a check to Building Pathways for \$25.00 if I am signing up for the first time. Once the application and check are received the application is complete. Checks are paid to the order of: Building Pathways Foundation. Application and Session Fees are due before the first class.

****Please note paying for the application fee doesn't sign you up for the sessions. You must pay the registration fee and session fees to be fully signed up for any of the classes. We do not prorate if your child is sick or out for any reason.***

****By signing below I understand that if my child is sick for any reason, no fees will be reimbursed or be transferred to pay for other weeks of social skills classes. No refunds or changes can be made once the payment has been made.***

Parent Signature

Date

Office Use Only:

Total Owed: _____

Paid Check: _____ Cash: _____ Zelle: _____ Venmo: _____ Other application: _____

Starting Date _____

Not Approved _____

Participant Name _____



SOCIAL SKILLS CLASSES APPLICATION PART 2

PARTICIPANT QUESTIONNAIRE

I like to _____

In school I am best at (or when I was in school) _____

I would like to find a job. Y or N What would you like to do? _____

I wish I was better at _____

I have friends. Y or N If yes, my friends names are _____

I would like to be more independent. Y or N

I am able to do these things on my own currently:

Brushing my teeth	Y	or	N
Picking out my clothes to wear each day	Y	or	N
I can bathe on my own	Y	or	N
I can do my own laundry	Y	or	N
I can swim on my own	Y	or	N
I can do all my own grocery shopping	Y	or	N
I can order my own food at a restaurant	Y	or	N
I can ride a 2 wheeled bike on my own	Y	or	N
I would like to talk to others better	Y	or	N
I would like more friends	Y	or	N
I feel I can talk well to others	Y	or	N
I have good eye contact when I talk to others	Y	or	N
I can stay on a topic when talking with others	Y	or	N
I don't know what to say to others	Y	or	N

Signature of Parent or Guardian

Date

Participant Name _____



SOCIAL SKILLS CLASSES APPLICATION PART 3

PARENT QUESTIONNAIRE

Socially, I would like my child to

Socially, my long term goals for my child are

Social behaviors I don't want to see in my child anymore (circle all that apply)

- Being too close to others
- Talking about the same things over and over
- Interrupting
- Touching others too much
- Correcting others
- _____

Social behaviors I want to see in my child now (circle all that apply)

- Initiate a conversation
- Advocate for themselves
- Talk more
- Have better eye contact
- _____

I chose your program because I want my child

Parent Name: _____ Date: _____

Parent Signature: _____

Participant Name _____



Participant Release and Waiver of Liability Form

This Release and Waiver of Liability (the “release”) executed on _____ (month/day/year) by _____ (“Participant”) releases, (“Building Pathways Foundation”), a nonprofit corporation organized and existing under the laws of the State of Florida and each of its directors, officers, employees, and agents. The Participant desires to participate in a program at Building Pathways.

- 1. Waiver and Release:** I, the participant release and forever discharge and hold harmless Building Pathways and its successors and assigns from any and all liability, claims, and demands of whatever kind of nature, either in law or in equity, which arise or may hereafter arise from the services at Building Pathways. I understand and acknowledge that this Release discharges Building Pathways from any liability or claim that I may have against Building Pathways with respect to bodily injury, personal injury, illness, death, or property damage that may result from the services provided by Building Pathways.
- 2. Insurance:** Further I understand that Building Pathways does not assume any responsibility for or obligation to provide me with financial or other assistance, including but not limited to medical, health, or any form of insurance.
- 3. Medical Treatment:** I hereby Release and forever discharge Building Pathways from any claim whatsoever which arises or may hereafter arise on account of any first-aid treatment or other medical services rendered in connection with an emergency during my participation in all activities related to Building Pathways Camps, Building Pathways Social Skill Classes, and Day Programs.
- 4. Assumption of Risk:** I understand that the services provided by Building Pathways may include activities that may be hazardous to me including, but not limited to swimming, biking, field trip and life skills training transporting via personal vehicles, involving inherently dangerous activities. I hereby assume risk of injury or harm from all the activities related to either Building Pathways camps or day programs and Release Building Pathways from all liability.
- 5. Photographic Release:** I grant and convey to Building Pathways all right, title, and interests in any and all photographs, images, video or audio recordings of me or my likeness or voice made by Building Pathways in connection with my participation in the camps or day programs. If I don't want my photo on any form of Social Media then a separate letter to the Building Pathways Director would need to be sent requesting no release of any photos on that platform.
- 6. Consent:** I authorize Building Pathways to obtain and release confidential information about Participant regarding Behavior Intervention Plan, Diagnosis, Assessments, and all Evaluations from _____ School or _____ Therapists.
- 7. Other:** I expressly agree that this Release is intended to be as broad and inclusive as permitted by the laws of the State of Florida and that this Release shall be governed by and interpreted in accordance with the laws of the State of Florida. I agree that in the event that any clause or provision of this Release is deemed invalid, the enforceability of the remaining provisions of this Release shall not be affected.

By signing below, I express my understanding and intent to enter into this Release and Waiver of Liability willingly and voluntarily.

Signature of Participant if over 18 or if under 18

Date

Participant Name _____

Signature of Parent/Guardian _____

Date _____



EMERGENCY INFORMATION

Today's Date: _____

Participant Name: _____ DOB: _____

Print Last Name, First Name

1) In Case of Emergency Contact

Relationship to Participant

Cell Phone _____ Email: _____

2) In Case of Emergency Contact

Relationship to Participant

Cell Phone _____ Email: _____

Insurance Carrier for Participant _____

ID # _____ Group# _____

Current Medical Doctor's Name _____ Phone _____

Current Dental Doctor's Name _____ Phone _____

In case of an emergency and 911 needs to be called, what is the preferred hospital you want your child taken to? _____

MEDICATION LIST

Name of Medication	Milligrams/Dosage	Used For

Will they need to take any medication during the day? Y or N *-If yes, ask for MEDICATION FORM*

Allergies _____ Require Epi-Pen to be carried? Y or N

Parent Signature: _____ Date: _____

Participant Name



Participant Signature (If over 18): _____