



Autism Assistance Dog Application

Highland Canine Training, LLC
145 Foxfield Drive
Harmony, NC 28634
www.autismassistancedog.com
866.200.2207

Parent / Guardian Information

Name _____ Parent / Guardian *(circle one)*
Street Address: _____
City _____ State _____ Zip _____
Home phone (____) _____ - _____ Cell (____) _____ - _____ Other (____) _____ - _____
Email Address _____

Name _____ Parent / Guardian *(circle one)*
Street Address: _____
City _____ State _____ Zip _____
Home phone (____) _____ - _____ Cell (____) _____ - _____ Other (____) _____ - _____
Email Address _____

Childs Information

Name _____ D.O.B _____
Sex *(circle one)* Male Female Height _____' _____" Weight _____ lbs

Birth Order *(circle one)* 1st 2nd 3rd 4th other

School Name _____ Public / Private *(circle one)*
Street Address: _____
City _____ State _____ Zip _____
Office phone (____) _____ - _____ County _____ District _____

Doctors Name _____
Office Name *(if applicable)* _____
Street Address: _____
City _____ State _____ Zip _____
Office phone (____) _____ - _____

Primary Diagnosis _____
Age at time of Diagnosis _____
Secondary Diagnosis _____

With whom does the child live? _____

How many hours per week is the child in school or therapies _____

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

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

(Attach sheet if necessary)

List medications, dosage and frequency: _____

We currently reside in a *(please circle)* house apartment duplex

Other children in the home:

Name _____ D.O.B _____

Sex *(circle one)* Male Female

Name _____ D.O.B _____

Sex *(circle one)* Male Female

Name _____ D.O.B _____

Sex *(circle one)* Male Female

Name _____ D.O.B _____

Sex *(circle one)* Male Female

Your residence currently has: *(please circle)* fenced yard enclosed area other _____

Do you have other pets? (list species, breed, age and sex) _____

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

Have you previously owned a service or assistance dog? _____

Please indicate any of the following conditions that may apply. Attach additional pages if necessary to describe any of the behaviors below.

	NA		Mild			Moderate			Severe		
Seizures	0	1	2	3	4	5	6	7	8	9	10
Panic Attacks	0	1	2	3	4	5	6	7	8	9	10
Violence	0	1	2	3	4	5	6	7	8	9	10
To self	0	1	2	3	4	5	6	7	8	9	10
To others	0	1	2	3	4	5	6	7	8	9	10
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
Difficulty 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 runs away	0	1	2	3	4	5	6	7	8	9	10

The information on this application; is correct to the best of my knowledge.

Applicant signature _____ Date _____

Print Name _____ Relationship _____

