



6-Week Intensive Summer Camp Application

Child Name: _____ Child DOB: _____

Parent Name: _____ Parent Phone: _____

Parent E-mail: _____ Home Address: _____

Does child have an Autism Spectrum Disorder (ASD) Diagnosis? YES NO

Does child have a 12-month IEP? YES NO

Does child have a Behavior Intervention Plan at school? YES NO

Does child have a 1:1 para at school? YES NO

Briefly describe child's current educational placement:

Briefly describe child's current academic programming:

Briefly describe child's current communication abilities:

Please mail completed application to:

Eden II Diagnostic and Outreach Center
2285 Victory Blvd, Ste 3
Staten Island NY, 10314
Or Fax to: 718-698-5791