



166 Patterson Avenue, Suite 8
Shrewsbury, NJ 07702
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3349 Route 138 Bldg B-Suite A
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Lunch Bunch/Breakfast Club Registration Form

Child's Name _____ Sex _____ Age _____
Date of Birth _____ Mother's Name _____ Father's Name _____
Address _____ City _____ State _____ Zip _____
Home # _____ Mother's Cell # _____ Father's Cell # _____
E-Mail _____

Please list all medical issues/medications or allergies that your child has:

Services at Abilities in Action: PT ST OT NONE
Other therapies outside of AIA: PT ST OT NONE Location: _____

What does your child's diet currently consist of? What are your child's favorite foods?

What is one food that you would love for your child to eat?

How does your child react when new foods are introduced? Can they tolerate new foods on their plate or will they touch the food?

List any foods that your child used to eat but will not eat now?

Does your child have any difficulty safely chewing or swallowing foods? If yes, explain.

How long will your child sit at the table during mealtime?

What are your goals for your child?

Any other information we should know?

Times: Mondays 9-10am Tuesdays 12-1pm Tuesdays 2-3pm Thursdays 2-3pm

Dates: June 30-August 21, 2025 (8 sessions)

Cost: \$400

*Enrollment fee is due by May 15, 2025. If your child is absent, the group fee is non-refundable. The group is not submittable to insurance.

Size: 4-6 children per group

**A minimum of 3 children is required to run the group. If we do not receive minimum enrollment, the camp will be canceled and tuition will be reimbursed.*

ENROLLMENT CRITERIA

- Ages: grouped by age 3-4 year-olds, 5-7 year-olds, 8-10 year-olds
- Can communicate their wants and needs
- Ability to interact well with peers
- Can remain seated at a table for periods of 15 minutes
- Can participate in group activities without need for one-on-one assistance.
- Unfortunately, children are not eligible for our groups if they have self-injurious behaviors/aggression.

By signing below, I acknowledge that I understand and agree to Abilities in Action policies.

Signature:

Date:

**Mail completed enrollment form and check to:
Abilities in Action
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Parent Acknowledgement Regarding Allergies

Child's Name: _____

Date: _____

My child has the following allergies:

Allergy: _____ ingestion inhalation/airborne contact

Symptoms of exposure: _____

<input type="checkbox"/> hives	<input type="checkbox"/> itchy throat	<input type="checkbox"/> diarrhea	<input type="checkbox"/> skin rash/hives Location:
<input type="checkbox"/> vomiting	<input type="checkbox"/> swelling	<input type="checkbox"/> anaphylaxis	<input type="checkbox"/> Other:

Treatment: Medication: _____

Exposure requires immediate attention: Yes No

Has your child ever experienced anaphylaxis? Yes No

My child has an EpiPen for this allergy: Yes No

Allergy: _____ ingestion inhalation/airborne contact

Symptoms of exposure: _____

<input type="checkbox"/> hives	<input type="checkbox"/> itchy throat	<input type="checkbox"/> diarrhea	<input type="checkbox"/> skin rash/hives Location:
<input type="checkbox"/> vomiting	<input type="checkbox"/> swelling	<input type="checkbox"/> anaphylaxis	<input type="checkbox"/> Other:

Treatment: Medication: _____

Exposure requires immediate attention: Yes No

Has your child ever experienced anaphylaxis? Yes No

My child has an EpiPen for this allergy: Yes No

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<input type="checkbox"/> vomiting	<input type="checkbox"/> swelling	<input type="checkbox"/> anaphylaxis	<input type="checkbox"/> Other:

Treatment: Medication: _____

Exposure requires immediate attention: Yes No

Has your child ever experienced anaphylaxis? Yes No

My child has an EpiPen for this allergy: Yes No

Parent Acknowledgement Regarding Allergies

It is the responsibility of the child's parent/guardian to inform Abilities in Action if your child has allergies, as well as if the allergies require immediate medical attention, such as administration of oral medications or the EpiPen, and to bring the prescribed unexpired medications to each session.

If your child has known allergies that require immediate medical attention, the parent/guardian is not permitted to leave the premises while your child is receiving therapy.

It is important to notify your child's therapist immediately if your child's allergy status changes. Your child's therapist will attempt to eliminate the use of known allergens in instructional tools and materials, arts and crafts projects, or incentives. The staff at Abilities in Action is trained in general emergency procedures. However, the staff at Abilities in Action does not have formal training in the administration of EpiPens and are not permitted to give medication to our patients. Additionally, Abilities in Action does not have EpiPens on site. If your child is exhibiting signs or symptoms of an allergic reaction or anaphylactic shock, we will notify the parent/guardian and call 911.

Release of Liability

- I agree to bring unexpired allergy medications that are prescribed for my child to my child's sessions at Abilities in Action.
- I understand that my child's parent/guardian is responsible for the administration of all medications to my child, including the EpiPen, in the event of suspected anaphylactic shock.
- I understand that Abilities in Action will not administer medication or the EpiPen in the event of an allergic reaction. If medication has been left with the child, it will be given to EMS upon arrival.

Printed Name of Child

Printed Name of Parent/Guardian

Signature of Parent