



School for Autistically Impaired Learners, SAIL
Enroll At Any Time!!!

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Date Received _____ U.S. Postage, Delivered, Faxed, E-mailed

Child's Name _____ Age: _____ DOB: _____ Gender _____

Child's Address _____ City, State, Zip Code _____

School District of Residence: _____ County _____ State _____

Mother's Name/Address _____

Father's Name/Address _____

Contact Numbers- Home _____ Cell _____ Fax _____

E-mail Address _____

Is your child currently enrolled in a public setting with an active IEP? _____

Has your child received an Evaluation Team Report (ETR)? _____

Has your child been diagnosed with autism or suspected to demonstrate behaviors within the autistic spectrum disorders (ASD) YES ___ NO ___ [not to worry if "No"
~ SAIL serves children suspected with autism.]

Do you have a current Individualized Education Plan (IEP)? YES ___ NO ___

Have you applied for the Ohio Autism Scholarship Program? YES ___ NO ___

____ **Please enroll my child in the first opening within SAIL.**

____ **Please contact me upon receipt of this SAIL application.**

Signature of Parent/Guardian

Date