DOGS WITH WINGS ASSISTANCE DOG SOCIETY

11343 – 174 Street N.W.
Edmonton, AB T5S 0B7
Phone: (780) 944-8011
Fax: (780) 944-9571
Web: www.dogswithwings.ca
E-mail: elisa@dogswithwings.ca

AUTISM SERVICE DOG

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ *(please print name)* have applied to Dogs with Wings Assistance Dog Society to obtain and train with an *autism service dog* for my child, _____.
I understand that medical information and agency reports are required and I agree to release to Dogs with Wings Assistance Dog Society any and all requested and pertinent information about my child.

_____ _____

Date Parent/Guardian Signature

Dear Sir or Madam:

Your patient, _____, has applied to us for training with an *autism service dog*. Training and working with an *autism service dog* on an ongoing basis is rigorous. It is important that we adequately assess the applicant's abilities and are aware of any special needs. Therefore, we have asked the applicant to provide you with the following forms so that you may release certain information we consider relevant.

If you have any questions about what an *autism service dog* is, or what they can do, please feel free to contact us or check out our website.

You may, if you prefer, forward these forms directly to us rather than return them to your patient. Applications are not processed until our office has received all information requested from the applicant. Your completion of these forms, at your earliest convenience, would be most appreciated by your patient/client and us.

All information received will be kept in the strictest confidence and will only be used for the purpose for which it was intended.

Sincerely,

Elisa Irlam, GDMI

Director of Client Services

DOGS WITH WINGS ASSISTANCE DOG SOCIETY

AUTISM SERVICE DOG

MEDICAL REPORT

* Please print legibly

PERSONAL INFORMATION

Name of Patient: _____ Age: _____ Height: _____ Weight: _____

MEDICAL HISTORY

Patient's Medical Diagnosis: _____

_____

_____

_____

_____

Explain limitations and additional pertinent information: _____

_____

_____

_____

_____

_____

Please list all medications currently being taken by your patient.

MEDICATION	DOSAGE	CONDITION OR ILLNESS	SIDE EFFECTS EXPERIENCED BY YOUR PATIENT

MEDICAL HISTORY cont'd

Please check applicable boxes and provide details if necessary:

- ❑ High/Low blood pressure
- ❑ Heart disease
- ❑ Hemophilia
- ❑ Migraines
- ❑ Dizziness/Fainting/Blackouts
- ❑ Allergies & likely reactions
- ❑ Epilepsy
- ❑ Cancer
- ❑ Asthma
- ❑ Muscular weakness
- ❑ Rheumatic fever
- ❑ Impaired hearing
- ❑ Impaired sight
- ❑ Memory loss
- ❑ Reduced stamina
- ❑ Chronic pain
- ❑ Brittle bones
- ❑ Diabetes
- ❑ Convulsive seizures
- ❑ Coordination problems
- ❑ Stroke
- ❑ Hernia
- ❑ Polio
- ❑ Spasticity
- ❑ Depression
- ❑ Imbalance
- ❑ Infantile paralysis
- ❑ Nervous disorders
- ❑ Limited mobility
- ❑ Skin sensitivity
- ❑ Speech impediment

Details:

_____

_____

_____

Is there any other information, you feel is pertinent, that may affect the applicant's ability to work with an autism service dog?

_____

_____

_____

_____

_____

Physician Name: _____ Date: _____

(Please print name)

Physician Address: _____

Physician Signature: _____ Phone #: _____

***NOTE: PLEASE RETAIN A COPY OF THIS COMPLETED FORM FOR YOUR FILES**