Submission Date _____

Quest Swims Preliminary Application

Please complete this form and submit it with all other supporting materials. Applicants will be contacted once the form is reviewed. Quest Kids will make every attempt to provide assistance.

Child's Full Name _____ Date of Birth _____

Parent's Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email Address _____

Diagnosis _____ Date of Diagnosis _____

Send a copy of the front and back of insurance card as well as diagnosis and ABA referral on letterhead.

Please specify medical conditions (ex: seizures, cerebral palsy, pica, g-tube, hearing/vision impaired, etc.)

_____

_____

Is your child potty trained? ◯ Yes ◯ No

Behaviors/Areas of Concern _____

_____

Days/Times Preferred _____

_____

_____

Has your child taken any previous swimming lessons? ◯ Yes ◯ No

Mail or fax completed application to: Quest Kids
500 E. Colonial Dr.
Orlando, FL 32803
407.218.4303

_____

FOR OFFICE USE ONLY:

Primary Therapist _____