



## Service Dog Application (Child)

Forever In My Heart Foundation  
476 Main St,  
Middletown, CT 06457  
[foreverinmyheartfoundation.org](http://foreverinmyheartfoundation.org)  
860-490-2170

### 1) Parent/Guardian Information (Required to be completed fully)

Name \_\_\_\_\_ Parent/Guardian (please circle)  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Cell ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Other ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Email Address \_\_\_\_\_  
Preferred method of contact \_\_\_\_\_

Name \_\_\_\_\_ Parent/Guardian (please circle)  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Cell ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Other ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Email Address \_\_\_\_\_  
Preferred method of contact \_\_\_\_\_

### 2) Child Information (Required to be completed fully)

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex - ☐ Male ☐ Female  
Height \_\_\_\_\_' \_\_\_\_\_" Weight \_\_\_\_\_ lbs.

School (*if applicable*) \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office phone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ County \_\_\_\_\_ District \_\_\_\_\_  
How many hours per week is your child in school? \_\_\_\_\_  
Do you plan to have your child (or an aide) take the Service Dog to school with

him/her?

☐ YES ☐ NO If yes, which one: Child or Aide

### 3) Medical Information (Required to be completed fully)

Doctor Name/Specialty \_\_\_\_\_

Office Name (*if applicable*) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Office phone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_

Age at Time of Diagnosis \_\_\_\_\_

Secondary/Tertiary Diagnosis \_\_\_\_\_

Please describe the most significant symptoms of your child's disability/illness and how it affects him/her (*attach separate sheet if necessary*):

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Check any and all medical problems that apply to your child:

☐ Fainting

☐ Asthma ☐ Heart Disease

☐ Diabetes ☐ Visual Impairment

☐ Other \_\_\_\_\_

List any allergies (food, animals, material, etc.) \_\_\_\_\_

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List medications (dosage and frequency): \_\_\_\_\_

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Would any of your child's current medications impair their ability to manage a service dog or impact learning how to work with your dog? ☐ YES ☐ NO

If so, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any cognitive difficulties (such as memory problems, inability to concentrate, etc.) that would affect their ability to manage a service dog?

☐ YES ☐ NO

If so, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any visual difficulties (such as degraded peripheral vision, lack of vision in one eye, etc.) that would affect your ability to manage a service dog?

☐ YES ☐ NO

If so, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any speech difficulties that would affect your ability to manage a service dog? ☐ YES ☐ NO

If so, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child require the assistance of an aide or family member for daily living skills?

☐ YES

☐ NO If yes, list the responsibilities of each individual.

Name	Daily Hours	General Duties	Telephone

Are they willing to assist with the daily care of a service dog, if needed? ☐ YES ☐ NO

What types of therapies is your child currently involved in?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many hours per week is he/she in therapies? \_\_\_\_\_

Do you anticipate future surgery or hospitalization for any reason for your child? ☐ YES ☐ NO

If so, explain. \_\_\_\_\_  
\_\_\_\_\_

Has there been any life changing events that has happened in the last 6 month? ☐ YES ☐ NO

If yes, explain  
\_\_\_\_\_  
\_\_\_\_\_

Do you anticipate any life changing events in the next year? ☐ YES ☐ NO

If yes, explain  
\_\_\_\_\_  
\_\_\_\_\_

Are there any limitations of either parent/guardian that would hinder handling of a service dog (medical, job requirements, etc.)? ☐ YES ☐ NO

If yes, explain \_\_\_\_\_  
\_\_\_\_\_

**a) Is your child diagnosed with Autism/Downs Syndrome (if no, go to next section)**

Please indicate any of the following conditions that may apply.

0 = Not Applicable, 1 = mild, 10 = severe

Also please indicate how often they occur.

N=Never, AN=Almost never, M=Monthly, W=Weekly, D=Daily, S=Multiple times a day

	HOW OFTEN											
Panic Attacks	0	1	2	3	4	5	6	7	8	9	10	_____
Violence to your Self	0	1	2	3	4	5	6	7	8	9	10	_____
Violence to Others	0	1	2	3	4	5	6	7	8	9	10	_____
Violence to Property	0	1	2	3	4	5	6	7	8	9	10	_____
Nightmares	0	1	2	3	4	5	6	7	8	9	10	_____
Night Awakenings	0	1	2	3	4	5	6	7	8	9	10	_____
Racing Thoughts	0	1	2	3	4	5	6	7	8	9	10	_____
Medication Side Effects	0	1	2	3	4	5	6	7	8	9	10	_____
Distractibility	0	1	2	3	4	5	6	7	8	9	10	_____
Self-stimulating Behaviors	0	1	2	3	4	5	6	7	8	9	10	_____
Disassociation	0	1	2	3	4	5	6	7	8	9	10	_____
Impulsivity	0	1	2	3	4	5	6	7	8	9	10	_____
Poor Judgment	0	1	2	3	4	5	6	7	8	9	10	_____
Self-care Deficits	0	1	2	3	4	5	6	7	8	9	10	_____
Managing Environment	0	1	2	3	4	5	6	7	8	9	10	_____
Difficulty Completing Tasks	0	1	2	3	4	5	6	7	8	9	10	_____
Child Bolts or Wanders Away	0	1	2	3	4	5	6	7	8	9	10	_____

Please describe any of the behaviors or conditions listed above, if necessary.

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**b) Does your child have mobility/stability issues (if no, go to next section)**

Limited in mobility? ☐ YES ☐ NO

If so, how? \_\_\_\_\_

Does your child use a wheelchair? ☐ YES ☐ NO If yes: ☐ Electric type: \_\_\_\_\_ ☐ Manual

Does your child use any other mobility aides? ☐ YES ☐ NO

If so, what? \_\_\_\_\_

Will you want the service dog to help support them while they are walking or getting up?

☐ YES ☐ NO

If so, describe \_\_\_\_\_

Is one side of your child's body stronger than the other? ☐ YES ☐ NO

Which side ☐ Left ☐ Right

Is your child restricted in their use of your hands or arms? ☐ YES ☐ NO

If so, describe \_\_\_\_\_

On a scale of 1-5 (1 = poor, 5= excellent), describe your child's:

<i>Upper body strength</i>	1	2	3	4	5
<i>Range of motion</i>	1	2	3	4	5
<i>Grip strength</i>	1	2	3	4	5
<i>Dexterity</i>	1	2	3	4	5

Is your child able to issue hand signals? ☐ YES ☐ NO

Does your child have spasms in your arms or legs? ☐ YES ☐ NO

If so, how quickly do they pass? \_\_\_\_\_

Does your child bruise easily? ☐ YES ☐ NO

Could a dog put his front legs up on your child's lap without hurting them? ☐ YES ☐ NO

Is your child able to issue voice commands in a clear, audible voice? ☐ YES ☐ NO

### c) Does your child experience seizures (if no, go to next section)

What type of seizures does your child have?

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How often does seizure activity happen? \_\_\_\_\_

Describe what the seizures look like \_\_\_\_\_

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Do you expect the dog to be trained for seizure alert and/or assistance? \_\_\_\_ Yes \_\_\_\_ No

If so, describe how you see the dog helping? \_\_\_\_\_

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### d) Is your child hard of hearing or have hearing loss (if no, go to next section)

Describe the extent of hearing loss (full, partial, both ears, one ear L/R, etc.)

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Does your child use any hearing aids? Yes/No If Yes, which types \_\_\_\_\_

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To what sounds would you like your dog to alert to? \_\_\_\_\_

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Is your child able to give verbal commands? Yes/No

Would you like your dog to be trained on verbal or hand signals? Verbal/Hand Signals

### e) Does your child have psychiatric issues (if no, go to next section)

What are the triggers? \_\_\_\_\_

Are there any indications (either verbal or visual) that your child does before having a panic attack, anxiety, night terrors, etc. (e.g. rubbing thighs, scratching head, hyperventilating, etc.)?

If yes, please describe \_\_\_\_\_

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### 3) Lifestyle Information (Required to be completed fully)

We currently reside in a ☐ House ☐ Apartment ☐ Duplex ☐ Other \_\_\_\_\_

Your residence currently has ☐ fenced yard ☐ enclosed area ☐ Other

\_\_\_\_\_ With whom does your child live?

\_\_\_\_\_ Other people in home:

Name	Date of Birth	Relationship

Do you have any current pets?

Species / Breed	Age	Sex	Name

Is anyone in your home allergic to dogs or pet dander? ☐ YES ☐ NO

If yes, Whom \_\_\_\_\_

Where does your child currently sleep? \_\_\_\_\_

Where do you want your child to sleep? \_\_\_\_\_

What size is your child's bed (King, Queen, etc.)? \_\_\_\_\_

How high off the floor is your child's bed (in feet)? \_\_\_\_\_

Where in the room will the Service dog be sleeping (in bed, on floor, in crate, etc.)

\_\_\_\_\_

Will the dog be allowed on the furniture/bed? Y/N

When do you get out of bed in the morning? \_\_\_\_\_

What time do you retire? \_\_\_\_\_

What type of recreational activities do you and your child do and how often?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where do you and your child like to go out in public?

\_\_\_\_\_

\_\_\_\_\_

Do you see yourself travelling a lot with your service dog? ☐ YES ☐ NO

What type of transportation do you see using (e.g. plane, car, bus, etc. please be specific with the frequency of each)\_\_\_\_\_

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#### 4) Service Dog Requirements (Required to be completed fully)

Who will be the primary handler of the service dog (does not have to be one person)

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How do you see a service dog helping your child?

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Do you have a preference for a dog breed? ☐ YES ☐ NO

If yes, which breed/type (e.g., Hypoallergenic, Labrador, etc.) \_\_\_\_\_  
and why? \_\_\_\_\_

Have you ever owned a dog in the past? ☐ YES ☐ NO

Who was responsible for the dog's training?

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Have you previously owned a service or assistance dog? ☐ YES ☐ NO

If so, explain. \_\_\_\_\_

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Do you have any experience working with animals? ☐ YES ☐ NO

If so, explain. \_\_\_\_\_

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After receiving your service dog, what are your hopes, goals, and fears?

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Where will the dog exercise and have playtime?

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Where will the dog be taken for toilet requirements? \_\_\_\_\_

How much exercise, on average, do you think a dog needs per day? \_\_\_\_\_

Describe your definition of exercise. \_\_\_\_\_

Who will help you with the dog's care if you are sick and cannot get outside:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Proximity to your home \_\_\_\_\_

On which side would you want the dog to work most of the time? (If you are right-handed, it is common for the dog to be trained to work on your left so your right hand can be free from leash, etc.) ☐ Left ☐ Right

Why? \_\_\_\_\_

Do you have any concerns regarding owning a service dog? ☐ YES ☐ NO

If so, describe. \_\_\_\_\_

Are you willing to participate in ongoing training sessions after receiving a service dog?

☐ YES ☐ NO

Will your family or housemates accept a trained dog as an equal partner in your house?

☐ YES ☐ NO

Please include any additional information that may be important for us to know.

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The information on this application is correct to the best of my knowledge. I understand that this preliminary application is required to be eligible for a packet application which will determine my suitability for a service dog. \_\_\_\_\_ (initials)

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_