Disability Ministry Child Information Intake Form

Our goal is to provide a time that is educationally and socially enriching to your child. We desire to give your child and family the personal care and attention needed to make coming to church a joyful and beneficial experience. We have included many areas of assessment, *please fill out only those areas that pertain to your child.* Thank you for helping us be able to serve your family better.

If there is any information you would like to keep private, please let us know. Thank you.

Please fill out parent/guardian information here.

First Name: _____

Last Name: _____

Mobile Phone: _____

Please fill out student information here.

Student's Name: _____

Student's Birthdate and Grade: _____

Student's Gender: _____

Disability or Special Need: _____

_____

Behavioral Information (Check All That Apply):

___ Anxious ___ Hyperactive ___ Plays Well Alone ___ Plays Well In Group

___ Transitions Easily ___ Transitions with Difficulty ___ Prefers Verbal Instructions

___ Prefers Visual Instructions ___ Responds Well to Correction

___ Responds to Correction with Difficulty ___ Can Become Aggressive

___ Sometimes Runs Away ___ Sensitive to Noise ___ Shy ___ Outgoing

List other sensitivities: _____
_____

My child's strengths are: _____
_____

My child is best comforted by: _____
_____

My child let's me know what he/she wants by: _____
_____

Describe a potential behavior issue your child may exhibit in class: _____
_____

What happens prior to, or what often causes, this behavior? Is it usually caused in response to something else? _____
_____

What cues are noticeable prior to the behavior: _____
_____

What is the best way to redirect this behavior: _____
_____

What is a positive reinforcement that is effective with your child, that can be done in class? _____
_____

Physical Information (Check All That Apply):

___ Impaired Vision ___ Blind ___ Impaired Hearing ___ Deaf

___ Needs Assistance with Sitting ___ Needs Assistance with Walking

___ Uses Crutches or Braces ___ Uses a Walker ___ Uses a Wheelchair

Please describe any special positioning needs your child may have: _____
_____

Seizures: ___ Yes ___ No

If yes, please give us more details on what to look for and how to respond: _____

Dietary Restrictions: ___ Yes ___ No

If yes, please explain further: _____

Forms of Communication (Check All That Apply):

___ Speech ___ Gestures ___ Sign Language ___ Communication Device

Can Understand What Others Say:

___ All of the Time ___ Most of the Time ___ Some of the Time

Please let us know how to best communicate with your child: _____
_____

Toileting Information:

___ Independent ____ Currently Toilet Training ___ Needs Assistance

How does your child indicate a need to use the bathroom: _____
_____

Additional Information:

What are some of your child's favorite things: _____
_____

Please tell us anything else you think we should know about your child: _____

How can we pray for your family: _____