Champions Club Intake Form

Date:_____

Child's Name: _____
(First) (Middle) (Last)

Date of Birth (MM/DD/YYYY)**:** _____ **Nickname/ Preferred Name:** _____

Gender: Male Female

Child's Diagnosis (e.g., Autism, Down Syndrome, Intellectually Disabled (ID), etc.): _____

_____

Is Child: Verbal / Nonverbal **Language Spoken:** _____ **Language Understood:** _____

Does your child communicate with American Sign Language (ASL)? Yes / No

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Home Phone:** _____

Does your Child have Siblings: Yes No

If yes, number and ages of siblings:_____

Child lives with: Mother / Father / Both Parents / Guardian

Mother's Name: _____ **Father's Name:** _____

Cell Phone Number: _____ **Cell Phone Number:** _____

Guardian's Name (if applicable): _____

Cell Phone Number: _____

Emergency Information

Person(s) to contact if parent/guardian cannot be reached in an emergency			
Full Name	**Relationship**	**Address**	**Cell Phone Number**

List medication currently prescribed by your child's doctor: _____

_____

_____

2. <u>Health Conditions (circle all that apply)</u>

Asthma Diabetes Epilepsy Brain Injury Hearing Impaired Vision Impaired

Other(s) (specify): _____

_____

3. <u>Dietary Restrictions/Allergies</u>

Can your child eat solid food? Yes / No

If no, does your child have a feeding tube? Yes / No

If yes, please tell us if and when we should call you so you can feed your child during service:

_____

Dietary Restrictions: _____

Food Allergies: _____

Medicine Allergies: _____

Other Allergies: _____

<u>Developmental Level:</u>

Please circle best estimate in each category below:

Physical	Cognitive	Emotional	Social
High	High	High	High
Medium	Medium	Medium	Medium
Low	Low	Low	Low

Education:

Is your child enrolled in school? Yes / No

Grade Level:_____

What type of classroom is your child in (mainstream, special needs)? _____

Does your chid have an IEP? Yes / No (if yes, please be prepared to provide a copy so we can model the same techniques your child is already familiar with from school)

Does your child receive Special Education Services? Yes / No

If yes, please describe services:_____

_____

_____

Behavior Information:

Challenging Behaviors	Consequences & Discipline Plan	Reinforces & Reward System
☐ Runs away ☐ Screams/Yells ☐ Uses Profanity ☐ Touches others inappropriately ☐ Aggressive to self (scratches, hits, bites, pulls hair) ☐ Aggressive to others (spits, scratches, hits, bites, pulls hair) ☐ Others (specify): _____ _____ _____ _____	☐ I do not have a discipline plan ☐ Redirect ☐ Time Out ☐ Loss of Privileges ☐ Spanking ☐ Loss of Items (e.g., toys/games, TV, computer) ☐ Others (specify): _____ _____ _____ _____	☐ Praise ☐ Food ☐ Books/Toys/Games ☐ Privileges ☐ Tangible Rewards (e.g., stickers, wristbands) ☐ Others (specify): _____ _____ _____ _____

What triggers challenging behavior for your child (e.g., loud noises, new situations, sudden changes in routine, etc.)? _____

_____

What calms your child (e.g., during a tantrum, when he/she is afraid)? _____

_____

_____

Restroom Needs:

Does your child use the restroom completely independently? Yes / No

If no, do you want your child to receive assistance using the restroom during Champions Club service? Yes / No (If no, we will call you if your child needs to use the restroom during service)

If yes, and if your child does not use diapers, please describe the type of toileting assistance your child needs:_____

_____

Does your child need diaper changes? Yes / No

If yes, do you want your child's diaper changed during Champions Club service? Yes / No
(If yes, please provide supplies. If no, we will call you if your child's diaper needs changed during service.)

Diapering Instructions (if answered yes above): _____

_____

Other Information:

How would you describe your child's personality? (playful, quiet, energetic, feisty, witty, shy,

enthusiastic, calm, etc.)_____

_____

_____

What are some of your child's favorite things - tv shows, books, classes at school, hobbies, foods, etc.?

_____

_____

_____

Is your child comfortable with physical touch (high fives, hugs, being given help with cutting/writing, etc.)? Yes / No

Is your child comfortable making eye contact with others? Yes / No

Does your child have any comfort item(s) they may bring into Champions Club with them (blanket, stuffed animal, book, toy, etc.)? Yes / No

If yes, please note_____

Please provide any additional information that would assist us in caring for your child: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How did you hear about Champions Club?_____

About Champions Club:

The mission of Champions Club is to provide an environment where exceptional children experience the love of God through the hearing of His word, engaging in worship, and partaking in fellowship with others. We as a ministry exist to connect these champion children with Jesus Christ and to fulfill His command to let the little children come to Him. Our heart is to help nurture children's relationships with Christ, teaching them of His love and showing them how to love others. Our specially-designed classroom space was created specifically to minister to champion kids' needs. Please be aware, however, we are a volunteer-staffed ministry, and are not trained or equipped to act in place of a primary care physician, occupational and/or physical therapists, or any other health professionals or services for exceptional children. We do not make any diagnoses or provide treatment of any kind. We are more than happy to provide contact information for local agencies who can help connect you and your family with such services if needed.

Application submitted by (please print):_____

Relationship to child:_____

Signature:_____