

Crossing Kids

Dear Parents,

It is our goal to cultivate a heart in your child that treasures God above all things. We want to partner with you, as your child's parent, to help create the best environment for your child.

One way we want to partner with you is by pairing your child one on one with a volunteer who will know your child's specific situation and how to best care for them and help them learn about Jesus.

Please complete this form as thoroughly as possible. We will respect your right to privacy and will share this information on a need-to-know basis only.

Feel free to write N/A for any area not applicable to your child.

Thank you!

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PARENT CONTACT INFORMATION

Date: _____

Name(s) _____

Best means of contact (select one or both):

Phone: _____ Best time to call: _____

Email: _____

Yes No Agape Kids can observe my child in the classroom to determine needs.

CHILD INFORMATION

Child's Name: _____ Age: _____ Grade: _____

My child has the following diagnosis(es), medical condition(s) or learning difference(s):

My child has the following area(s) of interest:

My child can do these things independently:

My child needs assistance with:

My child is uncomfortable with or has an aversion to:

A trigger-point for a potential meltdown is when:

When/if my child experiences a melt-down he/she calms when we:

Doing/seeing/experiencing this one thing is an important part of my child's routine:

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MEDICAL INFORMATION

My child has the following allergies and/or food sensitivities/restrictions: (____ none)

My child's allergies can be life threatening (circle) **Yes** **No**

and requires the use of an EpiPen **Yes** **No**

My child is prone to seizures (circle) **Yes** **No**

If yes, identify seizure trigger(s) and how we can prevent and/or respond:

My child's behavior may indicate a medical problem requiring immediate attention when:

COMMUNICATION

My child's main method of communicating is:

Speech: ___Words ___Phrases ___Sentences ___Gestures ___Sign Language

Other (describe):

My child can understand what others say:

___All the time ___Most of the time ___Some of the time ___Not at all

The best way to communicate with my child (special phrases, length of sentences, etc.):

EDUCATION

My child learns best using:

___ Visual cues/pictures ___Auditory cues/sounds ___ Movement

Other (describe):

My child has an Individualized Education Plan (circle) **Yes** **No**

My child currently receives the following therapies and/or special instruction in school:

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SOCIAL/BEHAVIORAL

My child has difficulty interacting appropriately with others (circle) **Yes No**

If yes, what suggestions do you have to help encourage your child participate in group activities?

My child tends to wander (circle) **Yes No**

If yes, what is the best response to this behavior?

My child demonstrates repetitive or self-stimulating behavior (circle) **Yes No**

If yes, please describe behavior and best response to this behavior:

My child demonstrates other behaviors that you should be aware of (circle) **Yes No**

If yes, please describe behavior and best response to this behavior:

SENSORY

My child has the following sensory sensitivity(ies):

___ Texture ___ Sound ___ Taste ___ Smell (specify any/all as needed here):

These are best managed by:

MOTOR

My child has difficulty with activities that require fine motor skills (i.e., cutting, coloring in, writing, etc.), including:

My child has difficulty with activities that require gross motor skills (i.e., throwing a ball, walking, running, climbing over things, etc.), including:

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OTHER INFORMATION

My child has the following needs not previously addressed (include toileting feeding schedules, medical concerns, specific behavior concerns or approaches, etc, here):

_____ Check here if the those working with your child would benefit from specific training or education and we will contact you to arrange.