

<b>Name:</b>	
<b>Informational Sheet</b>	
Date of Birth	
Nick Name(s)	
Parent(s) Name	
Cell Phone #	
Okay to Text?	Circle: YES or NO
<b>Help Us Get to Know You Child Better</b>	
I Enjoy:	
	<input type="checkbox"/> Books <input type="checkbox"/> Videos <input type="checkbox"/> Cars <input type="checkbox"/> Building <input type="checkbox"/> Bikes <input type="checkbox"/> Music <input type="checkbox"/> Water
	<input type="checkbox"/> Art <input type="checkbox"/> Walking <input type="checkbox"/> Helping <input type="checkbox"/> Sports <input type="checkbox"/> Technology
I Get Frustrated When:	
	<input type="checkbox"/> Loud Noises <input type="checkbox"/> Bright Light <input type="checkbox"/> Darkness <input type="checkbox"/> Being Touched
	<input type="checkbox"/> People Are In My Space <input type="checkbox"/> Talking <input type="checkbox"/> I'm Hungry <input type="checkbox"/> I'm Tired
You Can Help Me Calm Down By:	
	<input type="checkbox"/> Food or Drink <input type="checkbox"/> Quiet Time <input type="checkbox"/> Talking With Someone
	<input type="checkbox"/> Hugs <input type="checkbox"/> Using Technology <input type="checkbox"/> Music <input type="checkbox"/> Videos

P.O. Box 310  
Louisville, TN 37777




865.984.5178



info@abilityministry.com  
www.abilityministry.com



<b>Dietary Restrictions:</b>	
	<input type="checkbox"/> Milk <input type="checkbox"/> Dyes <input type="checkbox"/> Nuts <input type="checkbox"/> Gluten <input type="checkbox"/> Bottle <input type="checkbox"/> Tube Feed
<b>Restroom Needs:</b>	
	<input type="checkbox"/> Independent <input type="checkbox"/> Diaper <input type="checkbox"/> Ok, But Needs Supervised
<b>Sensory Needs:</b>	
<b>Communication:</b>	
	<input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Sign Language <input type="checkbox"/> Communication Devise
	<input type="checkbox"/> Other
<b>Other Important Information:</b>	

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