

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE TO BETTER SERVE YOUR CHILD! Submit application to spectrumconnects@featsonv.org

Child's Name:				
Address:				
City:				
	Zip Code:			
Phone (1):		Phone (2):	Gender: F	M
DOB:	Email:			
Parent's Name:				
About the Chi	ld: what child likes/do	es not like:		
how he/she is doing at school:			any alle	ergies:
		does she/he struggle wit	h sensory processing?(circle all that	apply):
Touch – light – sou	na – smell - food			
Additional informa	tion about your child:			
Please list Dia	gnosis and/or de	eficits: (speech/physical/h	earing, etc.)	
Additional diagnos	is/deficits information	:		
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Interest/hobbies: Please circle all tha	at apply – movies child likes:			
video games: outdoors/indoors activities - legos - board games - puzzles -				
riding a bike – music – sports – running - swim	iming			
Additional interest/hobbies information:				
	circle all that apply - Tell us about if child is: verbal/non-verbal - res - uses a communication device: (iPad- Pecs).			
Additional communication skills information:				
a non-preferred activity – can child wait in a de	ase circle all that apply - can child transition from a preferred to esignated area for up to five minutes appropriately - emotional - yelling/screaming - hitting/kicking other - throwing objects			
Additional child's behavior information:				
Social Skills: Please circle all that app contact - gives high fives – comments – compl	y - independent and/or interactive play – physical boundaries - eye iments - name exchange - etc.)			
Additional social skills information:	Ç ,			
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