



SpectrAbilities Intake Form

While the SpectrAbilities program at Metro South Gymnastics Academy (MSGA) is an extracurricular activity, we encourage sharing medical information about your child that may be important for us to know. Our mission is to provide the highest quality of care to each and every child who enters our doors, tending to each of their individual needs. Please provide any information about your child that may help us ensure their safety, encourage growth, and create a positive environment for your child to thrive! Additionally, we always welcome suggestions for how we can improve our SpectrAbilities program and the intake process!

Date: _____

Student Name: _____ **Pronouns:** _____

Age: _____ **DOB:** ____ / ____ / ____ **Weight:** _____ **Height:** _____

Address: _____

Parent or Guardian 1: _____

Phone: _____ **Email:** _____

Parent or Guardian 2: _____

Phone: _____ **Email:** _____

Emergency Contact: _____

Phone: _____ **Email:** _____

Relationship to student: _____

Diagnoses:

Check yes and leave a comment in sections that apply to your child. Otherwise, check no.

| Past Medical History | Yes | No | Comments: last checked, practitioners, important information, precautions, concerns, etc. |
|------------------------------|------------|-----------|--|
| Allergies | | | |
| Relevant Medications | | | |
| Hearing | | | |
| Vision | | | |
| Neurological | | | |
| Psychological/ Emotional | | | |
| Respiratory | | | |
| Digestive | | | |
| Circulatory | | | |
| Skin | | | |
| Skeletal/ Muscular | | | |
| Chronic Health Conditions | | | |
| Other: | | | |

| Communication | Yes | No | Comments |
|--------------------------------------|------------|-----------|-----------------|
| Nonverbal | | | |
| Low Verbal | | | |
| Selective Mutism | | | |
| Vision | | | |
| Receptive Language Challenges | | | |
| Expressive Language Challenges | | | |
| Communication Devices | | | |
| Does your child express their needs? | | | |
| Other: | | | |

| Behaviors | Yes | No | Comments: current concerns, triggers, successful strategies for maladaptive behaviors, etc. |
|--|------------|-----------|--|
| Sensory-Seeking | | | |
| Sensory-Defensive or Sensory-Avoidant | | | |
| Attention | | | |
| Anxiety/Fears | | | |
| History of self-injurious behaviors or aggression towards others | | | |
| Anger or Defiance | | | |
| Tantrums or Meltdowns | | | |
| Irritability or Frustration | | | |
| Impulsivity | | | |
| Can your child follow 1-step directions? | | | |
| Can your child follow multi-step directions? | | | |
| Other: | | | |

Please provide insight into your child's current strengths and challenges in the following areas.

| Skill Areas | At age-level expectations | Below age-level expectations | Comments: current strengths, current challenges, etc. |
|--|---------------------------|------------------------------|---|
| Fine Motor (writing, coloring, holding utensils, picking up objects, etc.) | | | |
| Gross Motor (walking, running, jumping, crawling, crossing midline, reaching arms over head) | | | |
| Balance and Coordination | | | |
| Overall Strength and Muscle Tone | | | |
| Flexibility and Range of Motion | | | |
| Level of Independence in Daily Tasks (toileting, dressing, feeding) | | | |
| Other: | | | |

| Education | | | | | | | | | |
|---|--|------------------------|-------------|-----------------|-------------|-----|------------------------|------------------------|--|
| School and Grade Level | | | | | | | | | |
| Preferred Learning Style (circle all that apply) | <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 25%;">Visual</td> <td style="text-align: center; width: 25%;">Auditory</td> <td style="text-align: center; width: 25%;">Reading/Writing</td> <td style="text-align: center; width: 25%;">Kinesthetic</td> </tr> <tr> <td style="text-align: center;">1:1</td> <td style="text-align: center;">Small Group (1-3 kids)</td> <td colspan="2" style="text-align: center;">Large Group (3-6 kids)</td> </tr> </table> | Visual | Auditory | Reading/Writing | Kinesthetic | 1:1 | Small Group (1-3 kids) | Large Group (3-6 kids) | |
| Visual | Auditory | Reading/Writing | Kinesthetic | | | | | | |
| 1:1 | Small Group (1-3 kids) | Large Group (3-6 kids) | | | | | | | |
| Has your child ever had an IEP? | If so, are there any accommodations that would be useful for us to provide at MSGA? | | | | | | | | |
| Is your child receiving any services (PT, OT, speech, ABA)? | If so, please note the frequency and any additional information. | | | | | | | | |
| Other: | | | | | | | | | |

| | |
|--------------------|----------------------------------|
| <u>Strengths:</u> | <u>Limitations:</u> |
| <u>Likes:</u> | <u>Dislikes:</u> |
| <u>Motivators:</u> | <u>Triggers/Things to Avoid:</u> |

1) What are your goals for your child participating in the SpectrAbilities gymnastics program?

2) Is there anything else you think we should know about your child to ensure successful participation in the SpectrAbilities gymnastics program?

3) What is your child's availability to participate in a SpectrAbilities class (1x/week for 45 minutes)? Please list days and times.

4) Do you have any questions, comments, or concerns for the MSGA staff about the SpectrAbilities program?

Thank you for taking the time to complete this intake form.
We look forward to working with your child!