***Date*_____**
Email_____

Preferred Service:
Sunday at 9:00 a.m._____
Or
Sunday at 10:30 a.m._____

SEACOAST GRACE CHURCH

Champion's Club Application

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

Date of Birth (MM/DD/YYYY): _____ Nickname: _____ Gender: Male Female

Childs Diagnosis (e.g., Autism, Down Syndrome, Intellectually Disable (ID), etc.): _____

_____

_____

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

Home Address: _____

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

Does your Child have Siblings: Yes No **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

Persons 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. Health Conditions (circle all applicable)

Asthma **Diabetes** **Epilepsy** **Brain Injury** **Hearing Impaired** **Vision Impaired**

Other (specify): _____

3. Dietary Restrictions/Allergies

Can your child eat solid food? Yes / No **Feeding Instructions:** _____

Dietary Restrictions: _____

Food Allergies: _____

Medicine Allergies: _____

Does your child tend to put things in their mouth?

_____

Developmental Level *(please indicate best estimate)*

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

Is your child enrolled in school: Yes
Grade Level:
Does your child receive Special Education Services: Yes No

Behavior Information

Problem 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 ☐ 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 problem behaviors (e.g. Loud noises, certain activities)?_____

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

_____

Other Information

Does your child need diaper change? Yes / No *(if yes, please provide the necessary supplies)*

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