The Action Potential @ CMHA

27 Jenison Avenue - Johnson City, NY 13790

607-729-0591

"Yoga For Children With Special Needs" Casey Calvery (Instructor)

Child's Name _____ Age_____

School and Grade_____ Does child have IEP? YES / NO

Guardian's Names_____

Address_____

City:_____ State: _____ Zip: _____

Email: _____

Telephone (_____)-_____- _____

Child's Pediatrician Name _____Tel _____

Please list all disabilities, surgeries, conditions that the Child has had or current has

_____

_____

_____

_____

Allergies? Food_____

Medication_____

Environment_____

What is your Child's daily food intake? Picky Special Diet _____ Excellent Good Fair Poor

Whati is your Child's daily fluid intake? Poor Fair Good Excellent Special Diet _____

Does your child:

Have pain? Yes / No

Get at least 8 hours of sleep? Yes / No

Sleep through the night? Yes / No

Get him/herself dressed? Yes / No

Have bowel or bladder accidents? Yes / No

Has sensitivity to texture/noise? Yes / No

Wear glasses or hearing aid? Yes / No

Hold a pen/pencil on his/her own? Yes / No

Prefers quiet places, avoids crowds? Yes / No

Seeks self-sensory experiences? Yes / No

Have a change in behavior if schedule changes? Yes / No

Learn better with auditory directions? Yes / No

Learn better with visual directions? Yes / No

What would you like for Yoga to do for your child? Please Explain.

_____

_____

_____

Is your child currently being seen by any other therapists or healthcare profesionals?

_____

How did you hear about The Action Potential's "Yoga For Children With Special Needs" program?

Signature and printed name of guardian/s

_____