



FUZION SCHOOL OF DANCE ADAPTIVE DANCE FORM

Please Print

General Information

STUDENT INFORMATION:

First Name: _____ Last Name: _____ Birthdate: _____

Gender: Female Male Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Academic School: _____ Grade Level for 2017-2018 Academic Year: _____

PARENT GUARDIAN INFORMATION:

Name: _____ Relationship to Dancer: _____

Address (if different from above) _____ City: _____ State: _____ Zip: _____

Phone Number: () _____ Secondary Phone Number: () _____

Email Address (used from primary contact) : _____

Emergency Contact: _____ Emergency Phone Number: _____

Health History

<p>Delay/Disability:</p> <p><input type="checkbox"/> Autism Spectrum Disorder</p> <p><input type="checkbox"/> Down Syndrome</p> <p><input type="checkbox"/> Learning Disability</p> <p><input type="checkbox"/> Other (please identify)</p>	<p>Health Conditions:</p> <p>Please check all that apply (current and past)</p> <table border="0"> <tr> <td><input type="checkbox"/> ADHD</td> <td><input type="checkbox"/> Heart Complications</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Hospitalization</td> </tr> <tr> <td><input type="checkbox"/> Behavioral Obstacles</td> <td><input type="checkbox"/> Seizures/Epilepsy</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Hearing Impairment</td> </tr> <tr> <td><input type="checkbox"/> Emotional Obstacles</td> <td><input type="checkbox"/> Vision Impairment</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p>Please explain any checked items:</p>	<input type="checkbox"/> ADHD	<input type="checkbox"/> Heart Complications	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Behavioral Obstacles	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Emotional Obstacles	<input type="checkbox"/> Vision Impairment		<input type="checkbox"/> Other: _____
<input type="checkbox"/> ADHD	<input type="checkbox"/> Heart Complications												
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hospitalization												
<input type="checkbox"/> Behavioral Obstacles	<input type="checkbox"/> Seizures/Epilepsy												
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing Impairment												
<input type="checkbox"/> Emotional Obstacles	<input type="checkbox"/> Vision Impairment												
	<input type="checkbox"/> Other: _____												

Allergies: Please list all known



Questionnaire

Communication Needs:

Your child communicates best with:

- Words Phrases Sentences Other (please describe)

Your child processes communication:

- All Of The Time With Prompts Or With Time With Repetition Other (please describe)

Your child is comforted by:

- Verbal Reassurance/Prompting Body Movement Oral Motor Tasks Other (please describe)

Learning Style:

Please check all that apply

- Visual Signals Extended Transitions One-On-One Support Body Movement
 Auditory Signals Verbal Encouragement Spatial (visual) plans Other (please describe)

Does your child follow 2-step directions with spatial concepts? Yes No

Behavioral Management:

Your child is best redirected by:

- Verbal Prompting (countdown, multiple encouragements) Visual Prompting Physical Prompting

Other- please describe: _____

Additional information that you would like your dance teacher to know:
