

STUDENT PROFILE



Promise seeks to get acquainted with you and to better understand your student's needs. In order to assist us with this process, please complete the following survey to the best of your ability. Note that the acceptance or denial of your student's application is not dependent on religious affiliation and/or church attendance.

Date:

Full name of student:

Date of birth:

Developmental age:

Current school:

Grade:

Teacher:

Parent(s):

Phone:

Cell:

Email:

Address:

Religious Affiliation:

Current Diagnosis:

Do you believe this is accurate?

Does your child have a current IEP?

Background:

Any relevant information that may provide insight into your student's learning and/or behavior.

Tactile/ Behavioral Concerns:

- ___ doesn't recognize other's personal space
- ___ has difficulty being in close proximity to others
- ___ needs to touch and manipulate items
- ___ avoids messy projects
- ___ appears to have a need to chew things: pencils, clothes, etc.
- ___ frequently needs to wash hands
- ___ overly sensitive to touch
- ___ enjoys bath time
- ___ overly aggressive
- ___ doesn't like to take turns
- ___ appears to be inflexible
- ___ demands frequent adult attention
- ___ has temper tantrums; triggers: _____
- ___ has rigid rituals
- ___ perseverates on a topic or object; needs a lot of redirection
- ___ overly fearful of situations or objects: _____

Describe additional observations you have made:

Motor Concerns:

___ has been evaluated by an Occupational Therapist?

Name: _____

___ is currently in O.T.? Name of O.T. _____

___ has been evaluated by a Physical Therapist?

Name: _____

___ is currently in P.T? Name of PT: _____

___ avoids playground equipment; prefers to sit

___ avoids participation in sports

___ fatigues easily compared to peers

___ has awkward physical coordination

___ falls easily

___ bumps into things

___ has poor posture when sitting at desk

___ confuses left / right

___ has poor hand dominance

___ has difficulty coloring, drawing, cutting, writing

___ has trouble tying, buttoning and zipping

___ has difficulty riding a bike

___ craves movement of all kinds

___ difficulty remaining seated

___ unable to sit while eating

___ twirls / spins frequently

___ rocks unconsciously in chair or on the floor

Describe any additional observations you have made:

Visual Concerns:

- ___ wears glasses
- ___ is under the care of an Ophthalmologist? Name: _____
- ___ is under the care of an Optometrist? Name: _____
- ___ has had vision therapy
- ___ reverses or inverts letters or numbers more than average for age
- ___ forms letters and numbers with difficulty
- ___ has trouble with puzzles, mazes and hidden pictures
- ___ has trouble copying from the board
- ___ displays poor eye contact
- ___ squints, rubs eyes or complains that eyes hurt
- ___ misjudges distances

Describe additional observations you have made:

Auditory Concerns:

- ___ has hearing loss
- ___ has history of ear infections
- ___ has had tubes
- ___ is under the care of an Ear Nose Throat (ENT) Dr? Name _____
- ___ is under the care of an Audiologist? Name _____
- ___ has been evaluated for Central Auditory Processing
- ___ extremely sensitive to sound
- ___ easily distracted by noise
- ___ has difficulty remembering information
- ___ unusual voice quality
- ___ history of a speech disorder
- ___ history of language impairment
- ___ easily frustrated with listening activities

Describe additional observations you have made:

Language Concerns:

___ has been evaluated by a specialist? Name: _____

___ is currently receiving services? How often: _____

___ has difficulty expressing ideas verbally or finding the right words

___ often uses words incorrectly

___ has trouble following directions

___ has difficulty with sequencing simple stories

___ word order is incorrect

___ grammar is awkward

Describe additional observations you have made:

Speech Concerns:

___ has difficulty pronouncing sounds: _____

___ is able to be understood by your family? _____ By others? _____

Describe additional observations you have made:

Social Concerns:

___ has difficulty making and maintaining friends

___ does not appear to be able to read facial expressions

___ does not appear able to read body language

___ little or no eye contact

___ responses to situations are inappropriate

___ overly serious

___ overly silly

___ overly sensitive

___ does not take ownership of behavior

Describe additional observations you have made:

Sleep Concerns:

- ___ has difficulty falling asleep
- ___ has difficulty staying asleep
- ___ has night terrors; graphic
- ___ fights bedtime
- ___ seems to function better in morning or at night? _____
- ___ has bedtime routine
- ___ set bedtime _____
- ___ sleeps in his/her own bed
- ___ how many hours of sleep does your student require?
- ___ how many hours does your student get on average? _____
- ___ my child needs _____ to fall asleep
- ___ restless sleep

Describe additional observations you have made:

Dietary Concerns:

- ___ aversion to textured foods
- ___ very particular to foods
- ___ prefers sweets
- ___ prefers carbs
- ___ will only eat a few specific foods: _____
- ___ is a messy eater

Describe additional observations you have made:

Medications:

my student takes the following medication(s): _____

how many milligrams: _____ how often: _____

purpose: _____

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purpose: _____

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how many milligrams: _____ how often: _____

purpose: _____

Describe additional information that may be helpful:

Healthcare Professionals:

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

What are your goals for your student:

Parent/Gaurdian signature:

Date

Parent/Gaurdian signature:

Date

Please return completed survey to:

Promise Christian Academy

800 Maryville Centre Dr. #227

Town and Country, MO 63017

T: 314-439-9711 / F: 314-336-0020