PEDIATRIC EXERCISE AND MOTOR DEVELOPMENT CLINIC

Department of Kinesiology - University of Georgia

Registration Form/Parent Questionnaire

Please answer the following questions. The information you provide will be held in the strictest confidence by Clinic personnel and will be of great value in understanding and working with your child.

Name of Child____ Date___________________

Age_______ Date of Birth_______________________ Gender________ Height_________

Weight_________ Grade_________ School____

Disability/Diagnosis____

Mailing Address____

Email Address____

Telephone Number____________________________ Cell Number_______________________________

EMERGENCY CONTACT____

Does your child have seizures?_____ If yes, what is the protocol?________________________________

Is your child toilet trained?_____ If NO, what assistance is needed?_____________________________

Any other health problems?____

What reinforces your child?
(order of preference)

____
____
____

Successful behavior mgmt techniques
(briefly explain)

____
____assertive discipline ____tokens
____privileges ____contracts

Successful adaptations/Modifications

____
____
____

Unsuccessful behavior mgmt techniques

____
____
____

LANGUAGE SKILLS/NEEDS____

EXPRESSIVE SKILLS/NEEDS____

MOTOR SKILLS/NEEDS____

Submit: 1) Registration Form/Parent Questionnaire, 2) Evaluation Release, and 3) payment for $30.00 (by check payable to: The University of Georgia). Send to: Pediatric Exercise and Motor Development Clinic, Department of Kinesiology, 308 Ramsey Center, 330 River Road, Athens, GA 30602.

Report to the Ramsey Student Center Lobby Entrance at 6:30PM on the first day of the Clinic.

PEDIATRIC EXERCISE AND MOTOR DEVELOPMENT CLINIC

Department of Kinesiology – University of Georgia

EVALUATION RELEASE

Name of Child: ____

Date: ____________________________

Parent(s) Telephone Number: __________________Cell Number:_____________________

Emergency Telephone Number: ____________________________

E-Mail: _________________________________

IMPORTANT! Have there been any recent changes in their disability? Improvements? Please list those here.

____
____
____
____
____
____

School:_____________________________Teacher:_______________________________

Medication: Taken For:

_______________________________________ ________________________
_______________________________________ ________________________
_______________________________________ ________________________
_______________________________________ ________________________

Use the space provided to list what priority physical skills or social behaviors you would like your child to work on this semester.

1. ____
2. ____
3. ____
4. ____

I give permission to Dr. Chris Modlesky, Ms. Julie Evans and/or their designated student clinicians to inquire about my child's disability/condition and my child's individualized program from the above listed school. I have every expectation that such inquiries will be subject to the strictest standards of professional confidentiality. I know of no reason my child should not participate in the activities offered in the clinic. Additionally, permission is granted to administer basic physical and motor assessments to allow formulation of an appropriate instructional program.

_____________________________________ ________________________

Signature *Date*