

**Child's Name:**

**Shine Ministry Informational Sheet**

**Date Of Birth**

**Nick Name(s)**

**Parent(s) Name**

**Cell Phone #**

**Okay To Text?**

**Circle: YES Or NO**

**Help Us Get To Know You Child Better**

**I Enjoy:**

Books  Videos  Cars  Building  Bikes  Music  Water

Art  Walking  Helping  Sports  Technology

**I Get Frustrated When:**

Loud Noises  Bright Light  Darkness  Being Touched

People Are In My Space  Talking  I'm Hungry  I'm Tired

**You Can Help Me Calm Down By:**

Food or Drink  Quiet Time  Talking With Someone

Hugs  Using Technology  Music  Videos

**Dietary Restrictions:**

Milk  Dyes  Nuts  Gluten  Bottle  Tube Feed

**Restroom Needs:**

Independent  Diaper  Ok, But Needs Supervised

**Sensory Needs:**

**Communication:**

Verbal  Non-Verbal  Sign Language  Communication Devise

Other

**Other Important Information:**

