

SPICE INFORMATION FORM

Child's Name: _____ DOB: _____

Phone: (____) _____ E-mail: _____

Mother's Name: _____ Father's Name: _____

General Education Background

School attended: _____ School District: _____

Type of classroom/program: _____

Speech/OT/PT Therapy: _____

Type of disability, if known: _____

Religious Education Background

Sacraments Received: ____ Baptism ____ Reconciliation ____ 1st Communion ____ Confirmation

Number of years of Religious Education _____

MEDICAL and PHYSICAL CONSIDERATIONS

Medication (Be specific)

Mobility: No need for assistance ____ Unsteady/needs a friend at his/her side ____ Crutches ____

Wheelchair w/no assistance ____ Wheelchair w/some assistance ____ Walker ____ Cane ____

Fine Motor Skills: Poor ____ Fair ____ Good ____

Other considerations: _____

Bathroom Skills: Independent ____ Needs some assistance ____ Total assistance ____ Catheter ____

Other considerations: _____

Allergies (Food, Environmental, Chemicals, Animals, Other) **Does your child have/use an Epi-Pen?** _____

Seizures: Any history of seizure disorder? *(Please specify type, and instructions in regard to responding to a seizure)*

Other relevant medical needs/information: _____

COMMUNICATION CONSIDERATIONS

Language skills: No difficulty in giving verbal responses _____ Speech is difficult to understand _____

Ask for child to repeat back _____ Yes or no responses _____ Processes slowly _____

Other considerations: _____

Written Communication: Child reads at _____ grade level

Needs someone to read with them _____ Cannot write or print, but uses typewriter/computer _____

Needs some assistance in writing _____ Child needs someone to write down responses _____

Other considerations: _____

Visual needs: Material in large print _____ Braille _____ Materials on tape _____

Hearing needs: Slight impairment _____ Hearing aid required _____ One good ear: left _____ right _____

Child is deaf _____ Knows ASL (American Sign Language) _____

Other considerations: _____

Learning style: (child best learns from) what he/she hears _____ what he/she sees _____

what he/she touches or handles _____ what he/she is involved in doing _____ what he/she talks about _____

Other considerations: _____

Attention Span: What helps hold your child's attention? What are his/her interests/talents?

Distractibility: What types of things are distracting or upsetting to your child? (visual stimuli, sounds, etc.)

Behavior:

Signs of unhappiness, agitation or emotionally upset are: _____

Events that might trigger these behaviors: _____

Ways to help calm and redirect your child: _____

Other considerations (What else do you want us to know about your child?): _____

