



SUPERHERO KIDS INTAKE FORM

Please Complete one form for each child to be registered

Child's Information	
Child's Name:	
Child's Birthday:	
Child's Home Address:	
Name of School:	
Parent/Guardian Information	
Parent/Guardian's Name:	
Relationship to child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Caretaker <input type="checkbox"/> Foster Parent <input type="checkbox"/> Case Manager <input type="checkbox"/> Other:
Parent/Guardian's Phone Number: <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL	
Parent/Guardian's Email:	
Home Address (if different from child):	
Parent/Guardian's Name:	
Relationship to child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Caretaker <input type="checkbox"/> Foster Parent <input type="checkbox"/> Case Manager <input type="checkbox"/> Other:
Parent/Guardian's Phone Number: <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL	
Parent/Guardian's Email:	
Who has custody of the child?	
Is there an order of protection in effect?	



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Emergency Contact Information	
(1) Emergency Contact Name	
Emergency Contact Relation to Child:	
Emergency Contact Phone: <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL	
(2) Emergency Contact Name	
Emergency Contact Relation to Child:	
Emergency Contact Phone: <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL	

Medical Information	
Child's Pediatrician/Primary Care Physician	
Child's Mental Health Professional	
Does the child have any allergies? (Including peanut/nut allergies)	<input type="checkbox"/> NO <input type="checkbox"/> YES (If yes please provide details)
Is the child currently taking medication?	<input type="checkbox"/> NO <input type="checkbox"/> YES (If yes please provide details)
Does the child have any dietary restrictions?	<input type="checkbox"/> NO <input type="checkbox"/> YES (If yes please provide details)



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<p>Does the child have any health concerns, problems, or discomforts we should be made aware of? <i>This includes diagnoses for ADD/ADHD, ODD, Autism, Asthma, Heart Problems, Seizure Problems, and/or diabetes</i></p>	<p><input type="checkbox"/>NO <input type="checkbox"/>YES (If yes please provide details)</p>
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<p>Does your child have any other special health needs?</p>	<p><input type="checkbox"/>NO <input type="checkbox"/>YES (If yes please provide details)</p>
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Education	
Is your child attending school now?	<input type="checkbox"/> NO <input type="checkbox"/> YES <i>Name of school:</i>
What is your child's grade level?	
Does your child require translation assistance?	<input type="checkbox"/> NO <input type="checkbox"/> YES
Does your child attend special education classes?	<input type="checkbox"/> NO <input type="checkbox"/> YES
Describe any challenges your child is having with school:	



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Family Relationships	
Is your current partner the child's biological parent?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT APPLICABLE
Does the child have any siblings?	<input type="checkbox"/> NO <input type="checkbox"/> YES
If YES, please list age and gender of siblings:	
Describe any relationship difficulties between your child and any member of the family, including yourself:	

History of Violence	
Please describe the last incident of abuse that your child has witnessed either directly or indirectly:	
How long has the abuse been going on?	
How often has the abuse occurred?	
What does the child do while the abuse is going on?	
How does the child behave immediately following an incident?	
How do you feel the abuse has affected your child?	



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Discipline	
How do you discipline your child?	
How does your child handle discipline?	

Personality & Goals	
Describe your child's personality and behavior:	
What would you like for your child to learn while participating in this group?	
Please provide us with additional information which you feel will help us better work with your child:	

Any behavior deemed inappropriate or dangerous by the program director will result in the immediate dismissal of the student from the program.



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Optional Information: Information provided below will be used for grant reporting and referral services only. For grant purposes, your name will NOT be attached to the information.

<p>Are you currently employed?</p>	<p> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Student <input type="checkbox"/> Caregiver/Stay-at-Home Parent <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed </p>
<p>Please estimate how much your family may earn each year:</p>	<p> <input type="checkbox"/> \$0 - 10,000 <input type="checkbox"/> \$10,001 - 25,000 <input type="checkbox"/> \$25,001 - 40,000 <input type="checkbox"/> \$40,001 - 50,000 <input type="checkbox"/> More than \$50,000 </p>
<p>Do you currently have health insurance?</p>	<p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>
<p>What is your race?</p>	<p> <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latinx <input type="checkbox"/> Black or African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Biracial <input type="checkbox"/> Other </p>

Group meets from 4:30 - 6:00 pm on Thursdays at 305 Highland Ave SW, Roanoke, VA.