



Date ____/____/____

Buddy Up Child Information Sheet

Child's Name _____ Birthday ____/____/____ Age _____

Mother's Name _____ Father's Name _____

Address _____

Home Phone # _____ Cell Phone# _____

E-mail Address _____

Which campus and service(s) do you normally attend/serve:

Keller: Sat. 5:00 Sun. 9:30 11:00 12:30

Haslet: 9:30 11:00 12:30

The goal of our Buddy Up ministry is to provide a time that is spiritually and socially enriching for your child. Our team members will be with your child in a one-on-one or small-group relationship within the larger classroom setting. Please keep this in mind as you answer the following questions. We are glad to use any items from home that would help make your child's experience at church familiar and enjoyable. All information will be kept confidential and be shared with only the appropriate teachers, buddies and leadership at Fellowship of the Parks for the purposes of teaching and ministering to your child.

1) How would you describe your child's special need? What is your child's primary diagnosis?

2) What behavioral patterns does a Room Leader/Buddy need to know (i.e. runs away, quiet, shy, yells, hits, aggressive, etc.)?

3) What suggestions do you have which would enable volunteers to serve your child more effectively? Our desire is to be consistent with the behavior modification plan you currently use.

4) What types of activities does your child enjoy?

Music _____ TV/DVD _____ Physical Movement _____
Crafts _____ Coloring _____ Playing with Toys _____
Other _____

5) What situations or activities does your child find difficult? (I.e. sitting still for long periods of time, handwriting, listening, getting along with others, etc.)

6) What activities do you recommend the Room Leader/Special Buddy avoid with your child?

7) Are there certain types of people that your child seems to respond to better than others? (i.e. older children vs. adult, male vs. female)

8) Is your child's speech understandable to those who do not know him/her? _____

9) How does your child communicate his/her needs?

9) Please circle your child's skill level in these areas:

| | | | | |
|----------|---------------------|------------------|--|------------------|
| Sits Up: | Independently | Needs assistance | Cushion/chair from home | Not at this time |
| Crawls: | Independently | Needs assistance | Not at this time | |
| Walks: | Independently | Needs assistance | Mobility device (please list) _____ | Not at this time |
| Drinks: | Can hold bottle/cup | Needs assistance | Cannot drink liquids | |
| Eats: | Feeds Self | Needs assistance | Cannot eat solids | |

10) Does your child have any food allergies/food restrictions? If so, please list.

11) Would you prefer to bring your own snack (food/beverage)? _____

13) Please describe your expectations/goals for your child during the hour he/she is in our care.

14) What other information/instructions would you like to share that would be helpful to volunteers working with your child? (i.e. how to encourage)

Thank you for completing this questionnaire. The information provided will be helpful in ministering to your child. Please return to Shannon McMahon-Keller or Angela Lippens-Haslet.