XTREME Cheer Inspiration

REGISTRATION

Please Note: *This form is required of all new Xtreme Cheer Inspiration participants.*

All information is confidential and viewed only by those involved in the assessment process. Please fill out and send to Alison Jacobson at alison@safetymom.com or 267 Thayer Pond Rd., Wilton, CT, 06897

In order for us to determine our ability to best serve your child in the Xtreme Cheer Program, please fill out in as much detail as possible:

Date _____

Name of Athlete _____

Address _____

City _____ State _____ Zip _____

Date of Birth ___ / ___ / ___ Current Grade _____ Height _____ Weight _____

T-shirt Size (Youth S, M, L or Adult S, M, L, XL) _____

Is there a need for financial assistance in order for your child to attend Xtreme Cheer? **Yes** **No**

Parent / Guardian / Emergency Contact Person _____

Address _____

City _____ State _____ Zip _____
(If different from players)

Home Phone _____ Cell Phone _____

Email (print clearly) _____

Name of Physician _____ Phone _____

In case of emergency, Hospital of choice _____

We do require at least one family member or representative to remain at the gym during practices and the venues during competitions. Thank you.

SPECIAL NEEDS INFORMATION

Name of Athlete _____

Mobility:
Ambulatory ___ Uses Walker ___ Uses Wheelchair ___ Needs Assistance ___
Uses Crutches ___ Uses Braces ___ Other _____

Communication:
Verbal ___ Non-verbal ___ Uses Sign Language ___
Uses Communication Board ___ Other _____

What motivates the player to perform/behave well? (check all that apply)
Verbal Praise ___ Food ___ Tangibles (prizes, stickers, etc) ___
Attention ___ Being left alone ___ Being allowed to _____

Fears and/or Dislikes: (loud noises, bugs, physical contacts, etc)

_____

_____

Please describe your child's special needs: (disability, special circumstances)

_____

_____

Does your child have any hearing, vision or balance deficits? (please explain)

_____

_____

What limitations, if any, would your child face in attending the Xtreme Cheer Program?

_____

_____

Does your child take any medication on a daily basis? Yes No
If yes, please list names of medications:

_____

_____

Does your child have any allergies? **Yes** **No**
If yes, please list them:

_____

_____

Does your child have any history of seizures? **Yes** **No**

Does your child have any special Dietary Restrictions/Issues/Food Allergies? **Yes** **No**
If yes, please list them:

_____

_____

Please list any challenging behaviors that your child may display and strategies used when these behaviors occur:

_____

_____

Please list any other ideas or information that you think we should know in order to make your child's team experience more pleasant and enjoyable:

_____

_____