

Sensory Haven LLC

Participant Intake Packet

Child Information

Child Name: _____

Date of Birth: _____

Diagnosis (optional): _____

Primary Language: _____

Parent/Guardian Information

Parent Name: _____

Phone Number: _____

Email Address: _____

Address: _____

Emergency Contacts

Phone: _____

Relationship: _____

Phone: _____

Relationship: _____

Medical Information

Physician Name: _____

Physician Phone: _____

Allergies

Does your child have any known allergies? ☐ Yes ☐ No

Allergy / allergen: _____

Reaction / symptoms: _____

Required response or emergency instructions: _____

Medications

Medications: _____

Medical Conditions

Medical Conditions: _____

Seizure History: ☐ Yes ☐ No

Elopement Risk: ☐ Yes ☐ No

Communication Method

☐ Verbal ☐ AAC Device ☐ Gestures ☐ Mixed

Sensory Sensitivities

Sensory Preferences

Behavioral Supports Helpful for My Child

Parent Consent

I authorize my child to participate in activities at Sensory Haven LLC and confirm that all information provided is accurate.

Parent Signature: _____

Date: _____