



carmelkidz Special Needs Visitor Card

1 Date: _____ Hour: 9:30 11:00
 Name: _____ Gender: male female Age: _____
 Type of Disability: _____
 School: _____ Wheelchair: Yes No

Most frequently used method of communication (verbalizations, vocalizations, eye gaze, gestures, facial expressions sign language, etc.): _____

Dietary needs (allergies, favorite foods/drinks ,etc.): _____

Acceptable foods/liquids that may be consumed (texture, size ,etc.): _____

Behavioral concerns (challenging behaviors, fears, etc.): _____

Physical needs (positioning needs, hearing/vision loss, etc.): _____

Medical conditions (seizures, asthma, diabetes, etc.) _____

Toileting needs: _____

Favorite activities: _____

Other information: _____

2 Street Address: _____

City, State, Zip: _____

Parent/Guardian: _____

Cell number (please put your phone on vibrate while in the building): _____

E-mail: _____

Please fill out the information if you have other siblings of school age children visting Carmel.

3 Names of other siblings of school age and their grade: _____ Grade: _____

_____ Grade: _____

_____ Grade: _____

Allergies/Health Concerns: _____