



Learning to Move, Moving to Learn

GMS Institute | Sensory Motor Integration Learning Enrichment
7233 Nathan Ct. | Manassas, VA 20109 | 703.392.5055 | www.gmskids.com

GMS S.M.I.L.E.™ Program Enrollment Application

Our Mission: The GMS Institute S.M.I.L.E.™ program serves students ages 3-6 with difficulties in areas of gross motor development, fine motor development, sensory integration, balance, visual motor development, problem solving, motor planning, cognitive functioning and language development. Our program serves students who are looking to supplement their weekly interventions with a comprehensive individualized sensory motor program including: students who have difficulty sustaining focus and attention in a class setting, children who have difficulty with self regulation, motivation and self esteem, children who have trouble controlling their bodies, children who have poor hand strength and control, children who have poor visual/auditory memory and children who are kinesthetic learners.

Do you feel your child has difficulties in on or more of the above areas? (circle) YES NO

Child's Name Last: _____ First: _____ MI: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Gender: (circle) MALE FEMALE

Recommended By: _____

Primary Residence (circle): w/Mother w/Father w/Both Parents

Other (specify): _____

Morning program days requested to attend (circle): MON TUE WED THU FRI

Afternoon program days requested (circle): TUE THU

Parent/Guardian Name Last: _____ First: _____ MI: _____

Address (if different from above): _____

City, State, Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Name of Employer: _____ Phone: _____

QUESTIONNAIRE

Has your child had an SMI Evaluation? (circle) YES NO Date if yes: _____

Has your child had the recommended amount of private lessons? (circle) YES NO

If yes, date of final private lesson: _____

If no, date privates anticipated to end: _____

Does child attend other school(s)? (circle) YES NO

If yes, please provide name(s) of other school(s): _____

Does child receive other types of therapy? (circle) YES NO

If yes, please provide therapy types: _____

Does your child have any allergies? (circle) YES NO

If yes, please list all allergies: _____

What do you hope for your child to achieve at GMS S.M.I.L.L.E.™? _____

Parent Evaluation

Please circle all words you feel describe your child:

- | | | | | |
|-----------------|-----------------|------------------|------------------|---------------|
| Bright | Social | Distractible | Leader | Restless |
| Loner | Honest | Disorganized | Outgoing | Sits out |
| Confident | Self-centered | Tests boundaries | Self disciplined | Passive |
| Negative leader | Focused/intense | Calm | Stubborn | Helpful |
| Dishonest | Introverted | Creative | Distracting | Perfectionist |
| Popular | Shy | Organized | Irritable | Motivated |
| Physical | Responsible | Anxious | Follower | Happy |
| Energetic | Irresponsible | Athletic | Immature | Assertive |
| Dependent | Unmotivated | Caring | Careless | Overprotected |
| Sad | Agreeable | Hurtful | Curious | Disobedient |
| Gives up | Musical | Impulsive | | |

ENROLLMENT ELIGIBILITY IS BASED ON SPACE AND READINESS

Signature: _____

Date: _____



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