The Advocacy Network on Disabilities

"Getting to Know Me"

Child's Name ______________________________

D.O.B. ____________________ Date ____________

We want to get to know your child better so that we can provide the best possible educational experience.
No one knows your child better than you. Tell us more about your child.

1. **We want to know about your child's favorite/least favorite toys/activities/rewards**:

Favorite	Least favorite
____________________	____________________
____________________	____________________
____________________	____________________

2. **What calms your child and what upsets your child?**

Calms	Upsets
____________________	____________________
____________________	____________________
____________________	____________________

3. **How does your child communicate?**
   - ❑ Verbally
   - ❑ Through gestures (i.e., pointing, pulling, blinking)
   - ❑ American Sign Language (ASL)
   - ❑ With vocalizations
   - ❑ With communication devices (i.e., pictures)
   - ❑ Other (please specify) ______________________________

4. What services does your child receive?

- ❑ Speech/Language Therapy
- ❑ Behavioral
- ❑ Physical Therapy
- ❑ Mental Health Counseling
- ❑ Occupational Therapy
- ❑ None

May we contact your service provider to better support your child? ❑ Yes ❑ No (Signed authorization form required)

5. Does your child require assistive devices or equipment? (i.e., braces, walker, wheelchair, communication device, insulin, nebulizer)

❑ Yes ❑ No If yes, please describe ______________________________

6. Do you suspect your child has a hearing or vision problem? ❑ Yes ❑ No

If yes, please describe ______________________________

7. **Which statement best describes your child's ability to move from one activity to another?**
   - ❑ Easily moves from one activity to the other
   - ❑ Needs assistance to move from one activity to the other

   Please explain ______________________________

8. **Does your child play/interact best** (please check all that apply):
   - ❑ Independently
   - ❑ With another child
   - ❑ Small group
   - ❑ Large group
   - ❑ Outdoor
   - ❑ Indoor
   - ❑ With adults
   - ❑ Additional comments: ______________________________

The Children's Trust

©2016 The Advocacy Network on Disabilities. All Rights reserved.

The Advocacy Network on Disabilities

"Getting to Know Me"

Child's Name ____________________

D.O.B. ____________________ Date ____________________

9. Do any of the following bother your child?

❏ Noise ❏ Texture (i.e., sand, water) ❏ Lights ❏ Touch (i.e., hugs)

❏ Smells ❏ Other ____________________

10. Does your child wander, run away or bolt? ❏ Yes ❏ No

If yes, what situations precede this behavior? ____________________

11. Is your child able to do the following activities by him/herself?

Use the toilet ❏ Yes ❏ No Walk/move about ❏ Yes ❏ No

Eat ❏ Yes ❏ No Wash his/her hands ❏ Yes ❏ No

If no, please describe what assistance is needed: ____________________

12. Does your child take medication? ❏ Yes ❏ No

Medication side effects staff should be aware of: ____________________

Is there anything else you would like to share about your child (i.e., allergies, diet, seizures, nosebleeds)?

____

____

____

____

©2016 The Advocacy Network on Disabilities. All Rights reserved.

The Children's Trust