



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: _____



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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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Walk/move about | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wash his/her hands | <input type="checkbox"/> Yes | <input type="checkbox"/> 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)?

