Generously Funded by
THE CHILDREN'S TRUST

"Getting to Know Me" YD K-5

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. **What are your child's favorite/least favorite toys/activities/rewards**?

Least Favorite	**Favorite**
_____	_____
_____	_____
_____	_____

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

Calms	**Upsets**
_____	_____
_____	_____
_____	_____

3. **What are your child's strengths and challenges?**

Strengths	**Challenges**
_____	_____
_____	_____
_____	_____

4. **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) _____

5. **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)

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

❑ Yes ❑ No If yes, please describe _____

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

If yes, please describe _____

8. Which statement best describes your child's ability to move from one activity to another?

❑ Easily moves from one activity to another ❑ Needs assistance to move from one activity to another

Please explain _____

9. Does your child play/interact best (please check all that apply):

❑ Independently ❑ With another child ❑ Small group ❑ Large group ❑ Outdoors
❑ Indoors ❑ With adults ❑ Additional comments: _____

10. Do any of the following bother your child?

❑ Noise ❑ Texture (i.e., sand, water) ❑ Lights ❑ Touch (i.e., hugs)
❑ Smells ❑ Other _____

11. Does your child wander, run away or bolt? ❑ Yes ❑ No

If yes, what situations precede this behavior? _____

12. 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: _____

13. 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)?

_____

_____