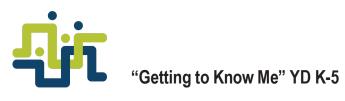


"Getting to Know Me" YD K-5

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CHILDREN'S
TRUST

	Child's Name		
	D.O.B	Date	
	want to get to know your child better so that we can proone knows your child better than you. Tell us more about	·	
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 □ With vocalizations □ Other (please specify) □ Through gestures (i.e □ With communication 		
5. \	What services does your child receive?		
Ma	☐ Speech/Language Therapy ☐ Behavioral ☐ Mental Health Counseling ☐ Occupation y we contact your service provider to better support your child		
6. I	Ooes 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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Child'	's Name
D.O.B	BDate
	child has a hearing or vision problem? ☐ Yes ☐ No
8. Which statement bes	st describes your child's ability to move from one activity to another?
•	from one activity to another Needs assistance to move from one activity to another
9. Does your child play	/interact best (please check all that apply):
' '	/ □ With another child □ Small group □ Large group □ Outdoors □ With adults □ Additional comments:
10. Do any of the followi	ing bother your child?
	☐ Texture (i.e., sand, water) ☐ Lights ☐ Touch (i.e., hugs) ☐ Other
-	nder, run away or bolt?
12. Is your child able to	do the following activities by him/herself?
Eat	☐ Yes ☐ No Walk/move about ☐ Yes ☐ No ☐ Yes ☐ No Wash his/her hands ☐ Yes ☐ No cribe what assistance is needed:
13. Does your child take	medication?
Medication side effects sta	aff should be aware of:
Is there anything else yo	ou would like to share about your child (i.e., allergies, diet, seizures, nosebleeds)?