



“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)?
