

Name:

Date of birth:

Nick Name(s):

Parent(s) Name:

Cell Phone:

OK to send texts? Yes ☐ No ☐

HELP US GET TO KNOW YOUR CHILD BETTER

I enjoy:

☐ Books ☐ Videos ☐ Cars ☐ Building ☐ Bikes ☐ Music ☐ Water

☐ Art ☐ Walking ☐ Helping ☐ Sports ☐ Technology

I get frustrated when:

☐ Loud noises ☐ Bright light ☐ Darkness ☐ Being touched

☐ People in my personal space ☐ Talking ☐ I'm hungry ☐ I'm tired

You can help me calm down by:

☐ Food/drink ☐ Quiet time ☐ Talking with someone

☐ Hugs ☐ Using technology ☐ Music ☐ Videos

Dietary restrictions:

☐ Milk ☐ Dyes ☐ Nuts ☐ Gluten ☐ Bottle ☐ Tube feed

Restroom needs:

☐ Independent ☐ Diaper ☐ OK, but needs supervision

Sensory needs:**Communication:**

☐ Verbal ☐ Non-verbal ☐ Sign-language ☐ Communication device

Other: _____

OTHER HELPFUL INFORMATION