Date: _____

Child's Name: _____
(First) (Middle) (Last)

Date of Birth (MM/DD/YYY): _____ Nickname: _____ Male / Female

Childs Diagnosis (e.g., Autism, Down Syndrome, Intellectually Disable (ID), etc.):

_____

_____

_____

Is Child: Verbal / Nonverbal

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Does your child have siblings: Yes / No Child lives with: Mother / Father/ Both Parents / Guardian

Mother's Name: _____ Father's Name: _____

Mother's Cell Phone Number: _____ Father's Cell Phone Number: _____

Guardian's Name (if applicable): _____ Guardian's Cell Number: _____

EMERGENCY INFORMATION: Persons to contact if parent/guardian cannot be reached

Full Name	Relationship	Address	Cell Number

List medication currently prescribed by your child's doctor: _____

_____

_____

Health Conditions **(circle all applicable)**

Asthma Diabetes Epilepsy Brain Injury Hearing Impaired Vision Impaired

Other (specify): _____

Dietary Restriction/Allergies

Can your child eat solid food? Yes / No Feeding Instructions: _____

Dietary Restriction: _____

Food Allergies: _____

Medicine Allergies: _____

Other Allergies: _____

Developmental Level **(please indicate best estimate)**

Physical	Cognitive	Emotional	Social
□ High □ Medium □ Low	□ High □ Medium □ Low	□ High □ Medium □ Low	□ High □ Medium □ Low

Education Information:

Is your child enrolled in school? Yes / No Grade Level: _____

Does your child receive Special Education Services? Yes / No

Behavior Information:

Problem Behaviors	Consequences & Discipline Plan	Reinforces & Reward Systems
□ Runs Away □ Screams/Yells □ Uses Profanity □ Touches others inappropriately □ Aggressive to self (scratches, hits, bites, pulls hair) □ Aggressive to others (spits, scratches, hits, bites, pulls hair) □ Others (specify):_____ _____	□ I do not have a discipline plan □ Redirect □ Time Out □ Loss of Privileges □ Loss of Items (e.g., toys/games, TV, computer) □ Others (specify): _____ _____ _____	□ Praise □ Food □ Books / Toys / Games □ Privileges □ Tangible Rewards (e.g., stickers, wristbands) □ Others (specify): _____ _____ _____

What calms your child (e.g., during a tantrum, when he/she is afraid) ? _____

_____

Other Information

Does your child need diaper change? Yes / No (if yes please provide necessary supplies)

Diapering Instructions: _____

_____

Please provide any additional information that would assist us in caring for your child: _____

_____

_____ (if more space is needed please use back of form)