# Getting To Know Your Child

Child's Name _____ Date of Birth _____

Address _____

Phone Number _____ Parents' Work Number(s) _____

Parents'/Caregivers' Cell Phone Number _____

In Case of Emergency, Contact _____

Health Card Number _____

Family Doctor _____ Phone Number _____

Medical Information

Primary diagnosis:

_____

_____

Secondary diagnosis (if applicable):

_____

_____

Is the diagnosis/disability(ies) continuous or recurrent/sporadic. Please explain:

_____

Equipment:

_____

Diet precaution:

_____

Allergy (please describe): _____

Carries an epi-pen? ☐ Yes ☐ No

Additional medical information:

Please check and provide information on areas that are challenging for your child, if any:

- ☐ Physical: _____
- ☐ Vision: _____
- ☐ Hearing: _____
- ☐ Memory: _____
- ☐ Attention: _____
- ☐ Learning: _____
- ☐ Behavioral: _____
- ☐ Mental Health: _____
- ☐ Intellectual: _____
- ☐ Other: _____

Please provide applicable information to help our volunteers minister to your child (for example: attention, tantrums, separation anxiety, shyness, aggressive behavior, triggers/dislikes/fears, etc.): _____

What are your child's interests/likes: _____

Ways that your child learns best:
☐ Visually ☐ Auditory ☐ Demonstration
Others:

Items that your child enjoys and can be used to…
Keep their attention: _____
As a reward: _____

Is your child bringing any medication with him/her? ☐ Yes ☐ No
If yes, please list: