



Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
(First) (Middle) (Last)

Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Nickname: \_\_\_\_\_ Male / Female

Child's Diagnosis (e.g., Autism, Down Syndrome, Intellectually Disabled (ID), etc.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is Child: Verbal / Nonverbal      Ever experienced seizures? Y / N

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

Seizures      Other (specify): \_\_\_\_\_

**Allergies**

Food Allergies: \_\_\_\_\_

Medicine Allergies: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

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

Physical	Cognitive	Emotional	Social
<input type="checkbox"/> High	<input type="checkbox"/> High	<input type="checkbox"/> High	<input type="checkbox"/> High
<input type="checkbox"/> Medium	<input type="checkbox"/> Medium	<input type="checkbox"/> Medium	<input type="checkbox"/> Medium
<input type="checkbox"/> Low	<input type="checkbox"/> Low	<input type="checkbox"/> Low	<input type="checkbox"/> 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
<input type="checkbox"/> Runs Away <input type="checkbox"/> Screams/Yells <input type="checkbox"/> Uses Profanity <input type="checkbox"/> Touches others inappropriately <input type="checkbox"/> Aggressive to self (scratches, hits, bites, pulls hair) <input type="checkbox"/> Aggressive to others (spits, scratches, hits, bites, pulls hair) <input type="checkbox"/> Others (specify): _____	<input type="checkbox"/> I do not have a discipline plan <input type="checkbox"/> Redirect <input type="checkbox"/> Time Out <input type="checkbox"/> Loss of Privileges <input type="checkbox"/> Loss of Items (e.g., toys/games, TV, computer) <input type="checkbox"/> Others (specify): _____ <hr/>	<input type="checkbox"/> Praise <input type="checkbox"/> Food <input type="checkbox"/> Books / Toys / Games <input type="checkbox"/> Privileges <input type="checkbox"/> Tangible Rewards (e.g., stickers, wristbands) <input type="checkbox"/> Others (specify): _____ <hr/>

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

**Other Information**

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

---



---



---



---

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