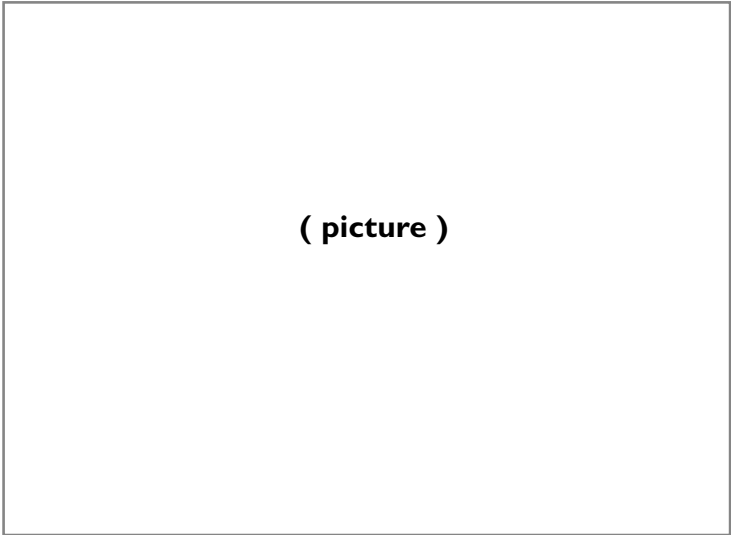




# About Me

---



I am:

-----  
-----  
-----

Things I like to do with my family:

-----  
-----  
-----  
-----

Things I like to do by myself:

-----  
-----  
-----  
-----



My friends are:

Four sets of horizontal dashed lines for writing, with a vertical dashed line in the middle of the second and third lines from the top.

Things I like to do with my friends:

Four sets of horizontal dashed lines for writing, with a vertical dashed line in the middle of the second and third lines from the top.

Things I do not like to do:

Four sets of horizontal dashed lines for writing, with a vertical dashed line in the middle of the second and third lines from the top.

People like to be with me because:

Four sets of horizontal dashed lines for writing, with a vertical dashed line in the middle of the second and third lines from the top.

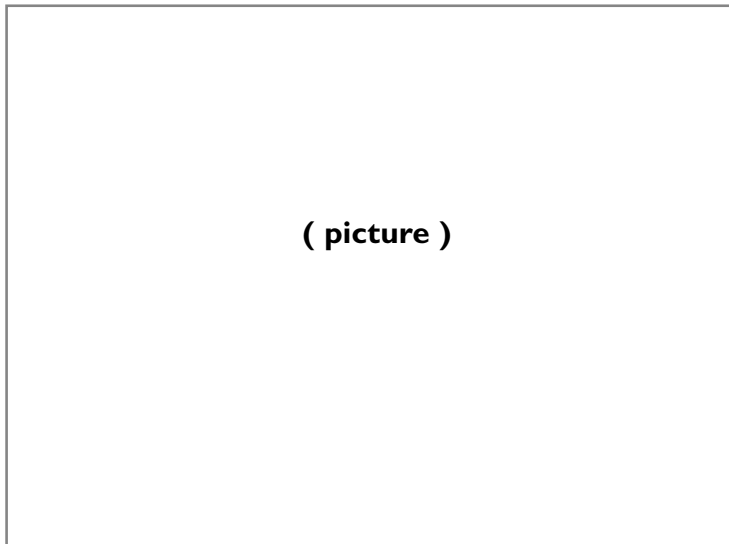
I let others know when I need something by:

Four sets of horizontal dashed lines for writing, with a vertical dashed line in the middle of the second and third lines from the top.



# About My Family

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My family includes:

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Things we like to do as a family:

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# Personal Information

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## Child / Youth

Name: .....

Date of birth: .....

Place of birth: .....

Health card number: .....

Diagnosis: .....

Allergies: .....

Home address: .....

Home telephone: ..... Daytime Telephone: .....

---

## Mother

Name: .....

Address (if different  
from child's): .....

Home Telephone: ..... Daytime Telephone: .....

---

## Father

Name: .....

Address (if different  
from child's): .....

Home Telephone: ..... Daytime Telephone: .....

---

## Siblings

Name: ..... Date of Birth: .....

.....

.....

Legal Guardian – If different than parents:

Name .....

Relationship .....

Address .....

Home phone ..... Daytime Phone: .....

Language spoken at home: .....

Interpreter needed?  Yes  No

Family Physician / Pediatrician

Name .....

Address .....

Phone .....

Dentist

Name .....

Address .....

Phone .....

Emergency Contact

Name .....

Relationship to child .....

Address .....

Home phone ..... Daytime Phone: .....

This form was last revised on:     
 Day Month Year



# Birth History

---

## **Pregnancy**

Please comment on mother's health and any complications during the pregnancy.

-----  
-----  
-----

## **Birth**

Gestation age: -----

Birth weight: -----

Method of delivery: -----

Apgar score at 1 minute: -----

Apgar score at 5 minutes: -----

Was oxygen required for respiratory support?       Yes    No

If yes, how long was it required? -----

How long was the hospital stay following birth? -----

Please comment on any medical complications in your child's first few months of life.

-----  
-----  
-----  
-----  
-----  
-----

### Family Health History

Please comment on any medical or health related issues for the following individuals:

Mother

-----  
-----  
-----  
-----

Mother's blood relatives

-----  
-----  
-----  
-----

Father

-----  
-----  
-----  
-----

Father's blood relatives

-----  
-----  
-----  
-----

Siblings

-----  
-----  
-----

### Allergies

Please comment on any allergies that your child has.

-----  
-----  
-----  
-----

# Playing

**Name:** \_\_\_\_\_

**Last updated:** \_\_\_\_\_

Activity	Age	Description
With toys (list)	_____	_____
Pretend / Imagination play	_____	_____
Games (list)	_____	_____
With other children	_____	_____

# Moving Around (Gross Motor)

Name: \_\_\_\_\_

Last updated: \_\_\_\_\_

Activity	Age	Description
Holding head up		
Rolling		
Sitting		
Creeping		
Pulling to stand		
Cruising		
Standing		
Walking with hand held		
Walking independently		
Running		
Jumping		
Climbing stairs		

# Using Hands (Fine Motor)

Name: \_\_\_\_\_

Last updated: \_\_\_\_\_

Activity	Age	Description
Reaching		
Grasping		
Releasing objects		
Using two hands together		
Transferring objects from one hand to the other		
Using a marker or crayon		
Using scissors		
Copying shapes		
Drawing a person		

# Feeding

**Name:** \_\_\_\_\_

**Last updated:** \_\_\_\_\_

Activity	Age	Description
Drinking from a cup	_____	_____
Eating pureed foods	_____	_____
Chewing solid food	_____	_____
Feeding self using fingers	_____	_____
Feeding self with a spoon	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# Hygiene

**Name:** \_\_\_\_\_

**Last updated:** \_\_\_\_\_

Activity	Age	Description
Wiping face	_____	_____
Washing hands	_____	_____
Using toilet when prompted	_____	_____
Toilet trained	_____	_____
Brushing teeth	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# Dressing

**Name:** \_\_\_\_\_

**Last updated:** \_\_\_\_\_

Activity	Age	Description
Removing clothes (describe items)		
Putting on clothes (describe items)		
Undoing fasteners (buttons, zipper...)		
Doing up fasteners (buttons, zipper...)		
Shoes and laces		
Other		

# Communication

**Name:** \_\_\_\_\_

**Last updated:** \_\_\_\_\_

Activity	Age	Description
<u>Understands words (describe)</u>		
<u>Uses gestures (describe)</u>		
<u>Follows instructions (describe)</u>		
<u>Makes sounds (describe)</u>		
<u>Says words (describe)</u>		
<u>Says phrases / sentences (describe)</u>		
<u>Uses symbols / communication aids (describe)</u>		

# Contacts: Health/Medical System

	<b>Name, Agency / Facility</b>	<b>Phone, Address, Email</b>
Family Doctor		
Pediatrician		
Specialists		
Occupational Therapists		
Physiotherapists		
Speech–Language Pathologist		
Psychologist		
Social Worker		
Nurse		
Nutritionist		
Other:		

Date \_\_\_\_\_

# Contacts: Education System

	<b>Name, Title</b>	<b>Phone, Address, Email</b>
Classroom Teacher		
Special Education or Resource Teacher		
Principal		
Consultants to School		
Director of Special Services / Special Education		
Superintendent of Schools		
Board of Education Trustees:		
Minister of Education		

Date \_\_\_\_\_

# Preparing Information Checklist

- What information is being shared?

-----  
-----

- Who will hear/receive this information?

■ ----- ■ -----  
■ ----- ■ -----

- What is the purpose of sharing this information?

- Teach and Inform  
 Help Reach a Decision  
 Develop Partnerships  
 Advocate  
 Other: \_\_\_\_\_

- Information to be shared:

-----  
-----  
-----  
-----  
-----

- How will the information be shared?

- Verbally  Visually  
 Writing  Other:

Who will receive a copy of the information?

-----  
 -----  
 -----

Adapted with permission from Nancy M. Draper Consultants Inc.

# Sharing Information About Your Child: Profile

Name:

Date:

## Things I like to do

I like:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> playing store        | <input type="checkbox"/> vacuuming and cleaning  | <input type="checkbox"/> reading          | <input type="checkbox"/> computer      |
| <input type="checkbox"/> writing              | <input type="checkbox"/> buying things by myself | <input type="checkbox"/> music            | <input type="checkbox"/> crafts        |
| <input type="checkbox"/> basketball           | <input type="checkbox"/> shopping                | <input type="checkbox"/> soccer           | <input type="checkbox"/> playing cards |
| <input type="checkbox"/> gardening            | <input type="checkbox"/> cooking                 | <input type="checkbox"/> walking          |  |
| <input type="checkbox"/> drama/plays          | <input type="checkbox"/> baseball                | <input type="checkbox"/> horseback riding |  |
| <input type="checkbox"/> talking on the phone | <input type="checkbox"/> road hockey             | <input type="checkbox"/> other: _____     |  |
| <input type="checkbox"/> ordering my own food | <input type="checkbox"/> swimming                | _____                                     |  |

## Places I like to go

I like to go to:

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> the library | <input type="checkbox"/> the park         | <input type="checkbox"/> the "Y"       |
| <input type="checkbox"/> the movies  | <input type="checkbox"/> shopping         | <input type="checkbox"/> visit friends |
| <input type="checkbox"/> the bank    | <input type="checkbox"/> the corner store | <input type="checkbox"/> other: _____  |
| <input type="checkbox"/> the mall    | <input type="checkbox"/> restaurants      | _____                                  |

## Things I find difficult

I have difficulty with:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> escalators     | <input type="checkbox"/> hot pots/pans | <input type="checkbox"/> new terrain         |
| <input type="checkbox"/> knives/cutting | <input type="checkbox"/> uneven ground | <input type="checkbox"/> other things: _____ |
| <input type="checkbox"/> steps/stairs   | <input type="checkbox"/> scissors      | _____  |

## Things I have to remember

Sometimes I forget:

- |   |  |
|---|--|
| <input type="checkbox"/> to wipe, flush, and wash with soap | <input type="checkbox"/> that I should not hug people        |
| <input type="checkbox"/> what I was asked to do             | <input type="checkbox"/> to finish my chores before I go out |
| <input type="checkbox"/> to brush ALL my teeth              | <input type="checkbox"/> to wash my WHOLE body when I bathe  |
| <input type="checkbox"/> to use my lists                    | <input type="checkbox"/> other things: _____                 |
|   | _____  |

## Other

-----

-----



# Phone Call Record Sheet

<input checked="" type="checkbox"/>	Date / Time	Person, Title, Organization	Phone Number / Fax
-------------------------------------	-------------	-----------------------------	--------------------

<input type="checkbox"/>			
--------------------------	--	--	--

Notes:  
-----  
-----

<input type="checkbox"/>			
--------------------------	--	--	--

Notes:  
-----  
-----

<input type="checkbox"/>			
--------------------------	--	--	--

Notes:  
-----  
-----

<input type="checkbox"/>			
--------------------------	--	--	--

Notes:  
-----  
-----

<input type="checkbox"/>			
--------------------------	--	--	--

Notes:  
-----  
-----

# Communication Between Preschool & Home

**Name:** \_\_\_\_\_

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

## Class Schedule

Calendar Time	
Journal	
Language	
Numbers	
Theme	
Story Time	
Computer	

<b>Music</b>	<b>Art</b>
<b>Gym</b>	<b>Library</b>

<b>sand</b>	<b>water</b>
<b>listening</b>	<b>blocks</b>
<b>puzzles</b>	<b>board games</b>
<b>shelf toys</b>	<b>book</b>

**Comments:**

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# Communication Between Elementary School and Home

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<b>Name:</b>	<b>Grade:</b>	<b>Date:</b>
--------------	---------------	--------------

Language Arts \_\_\_\_\_

Math / Arithmetic \_\_\_\_\_

Arts – Music, Drama, Art \_\_\_\_\_

Lunch \_\_\_\_\_

Recess \_\_\_\_\_

Physical Education \_\_\_\_\_

Social Studies \_\_\_\_\_

Teacher's signature: \_\_\_\_\_

Parent's signature: \_\_\_\_\_

Parent's comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Communication Between Secondary School and Home

---

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

Period One

School Signature \_\_\_\_\_ Home Signature \_\_\_\_\_

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

Period Two

School Signature \_\_\_\_\_ Home Signature \_\_\_\_\_

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

Period Three

School Signature \_\_\_\_\_ Home Signature \_\_\_\_\_

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

Period Four

School Signature \_\_\_\_\_ Home Signature \_\_\_\_\_

# Our Family Vision Statement

The family vision statement can help you make decisions for your child and family. It gives continuity and direction.

Use the following questions to get you started. Refer to pages 23–27 in the User's Guide.

1. What are your greatest dreams for your child?

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2. What are your greatest fears for your child?

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---

3. Think and talk about your basic family values (e.g., to have your child accepted for who he or she is)

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4. What are your goals for your child? (e.g., playing with other children in the neighbourhood, going to summer camp, living on his or her own, having friends)

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5. How do you like to be treated by one another in your family? (e.g., with respect, respect our privacy, etc.)

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# Appointment Schedule

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Name \ Year						



# Appointment Log

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Date	Who/Where	Purpose	Plans/Next Steps	Follow up?



# Preparation Notes For Meeting

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Q: What is going well at school; what do you like?

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-----  
-----  
-----  
-----  
-----  
-----

Q: What challenges are you having; what don't you like?

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-----  
-----  
-----  
-----  
-----  
-----

Q: What questions do you want to ask?

-----  
-----  
-----  
-----  
-----  
-----  
-----

# Team Meeting Summary Form

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

Location: \_\_\_\_\_

Team Meeting for: \_\_\_\_\_  
name of childTeam Leader: \_\_\_\_\_  
name of parentSupport Person/Recorder: \_\_\_\_\_  
name, organization

<input type="checkbox"/>	-----	<input type="checkbox"/>	-----
<input type="checkbox"/>	-----	<input type="checkbox"/>	-----
<input type="checkbox"/>	-----	<input type="checkbox"/>	-----
<input type="checkbox"/>	-----	<input type="checkbox"/>	-----
<input type="checkbox"/>	-----	<input type="checkbox"/>	-----

Purpose of Meeting: -----

Intended Outcome(s) of Meeting: -----

-----  
-----

Action Item #	Discussion	Action Required	Person Responsible for Action	Date to be done by	Done √
1.					
2.					
3.					
4.					

– Adapted with permission from P.R.O.S.P.E.C.T.S. Team Meeting Discussion Notes



# Self-Advocacy Plan for High School

**Learning style and study skills. These refer to the skills I used to gather, learn, and remember information, facts, or concepts:**

1. Picture in your mind your favourite class. What does that teacher do that makes it easy for you to learn and remember?

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2. Picture in your mind your worst class. What does that teacher do that makes it difficult for you to learn or remember?

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3. List materials or activities which have helped you learn in school.

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4. List any skills you would like to learn or improve upon for next year in order to do better in school.

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5. What training, job, or career do you want to pursue after high school?

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**Preferences for classroom learning. Check the way you learn best.**

1. I learn best when I work:

- by myself                       with a peer tutor                       with another student                       with a teacher or student teacher

 other: \_\_\_\_\_  
 \_\_\_\_\_

2. Activities I learn best from are:

- reading                                       discussion                                       working on a project  
 writing reports                               listening                                       watching videos  
 taking notes                               talking reports                               using study guides

 other: \_\_\_\_\_  
 \_\_\_\_\_

3. I do best on tests which are:

- multiple choice                               true/false                                       interview, discussion  
 matching                                       short answer                                       given in quiet setting  
 open notebook                               essay

 other: \_\_\_\_\_  
 \_\_\_\_\_

4. Classroom modifications I may need:

- extra time for tests                                       not to have spelling count  
 a notetaker for class                                       not to be called on to read aloud  
 extra notice before tests                                       extended time for assignments  
 special seating arrangements                                       have a copy of class notes put on board  
 be given enough time to copy class notes from board  
 be given visual clues (things to look at to help during a lecture)

 other: \_\_\_\_\_  
 \_\_\_\_\_
5. Describe yourself as a learner:  
 \_\_\_\_\_  
 \_\_\_\_\_