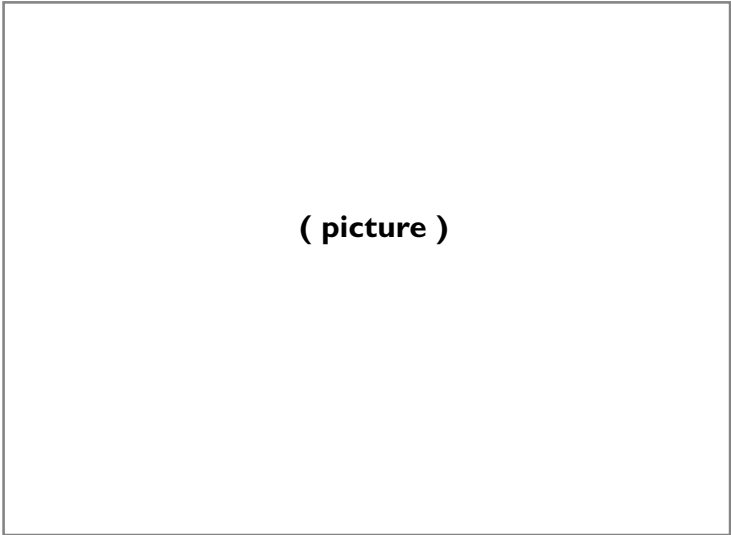




About Me



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 down the middle of the section.

Things I like to do with my friends:

Four sets of horizontal dashed lines for writing, with a vertical dashed line down the middle of the section.

Things I do not like to do:

Four sets of horizontal dashed lines for writing, with a vertical dashed line down the middle of the section.

People like to be with me because:

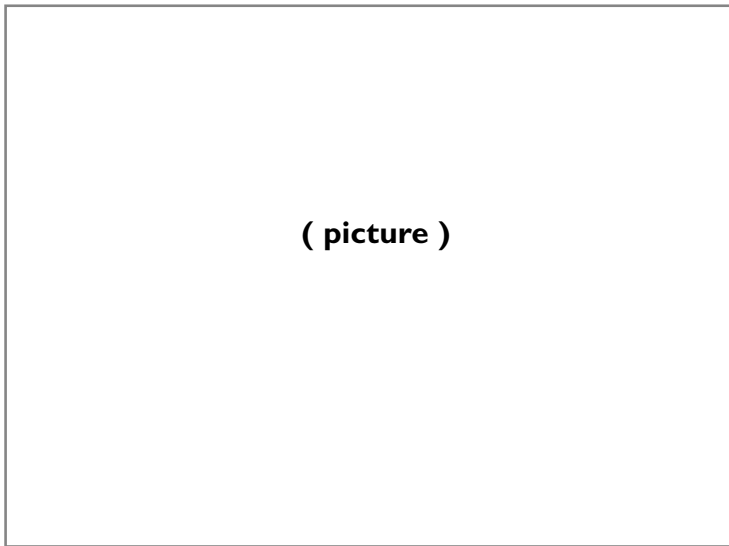
Four sets of horizontal dashed lines for writing, with a vertical dashed line down the middle of the section.

I let others know when I need something by:

Four sets of horizontal dashed lines for writing, with a vertical dashed line down the middle of the section.



About My Family



My family includes:

Things we like to do as a family:

Personal Information

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

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

Date _____

Contacts: Education System

	Name, Title	Phone, Address, Email
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	

Music	Art
Gym	Library

sand	water
listening	blocks
puzzles	board games
shelf toys	book

Comments:



Communication Between Elementary School and Home

Name:	Grade:	Date:
--------------	---------------	--------------

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?

2. What are your greatest fears for your child?

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

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)

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



Appointment Schedule

Name \ Year						



Appointment Log

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



Preparation Notes For Meeting

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

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

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?

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

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

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

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

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:

