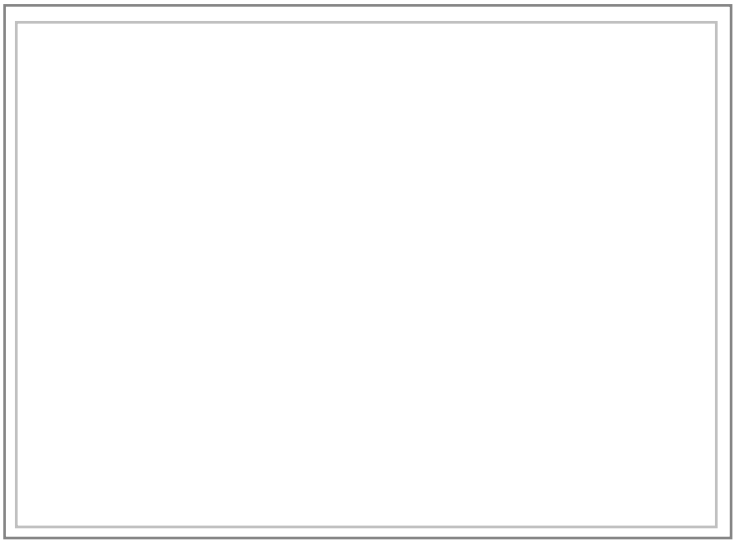
About Me



I am:

Things I like to do with my family:

Things I like to do by myself:

My friends are:

Things I like to do with my friends:

Things I do not like to do:

People like to be with me because:

I let others know when I need something by:

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
Understands words (describe)		
Uses gestures (describe)		
Follows instructions (describe)		
Makes sounds (describe)		
Says words (describe)		
Says phrases / sentences (describe)		
Uses symbols / communication aids (describe)		

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		
Superintendant 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:

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

Places I like to go

I like to go to:

- ☐ the library
- ☐ the movies
- ☐ the bank
- ☐ the mall
- ☐ the park
- ☐ shopping
- ☐ the corner store
- ☐ restaurants
- ☐ the "Y"
- ☐ visit friends
- ☐ other: _____

Things I find difficult

I have difficulty with:

- ☐ escalators
- ☐ knives/cutting
- ☐ steps/stairs
- ☐ hot pots/pans
- ☐ uneven ground
- ☐ scissors
- ☐ new terrain
- ☐ other things: _____

Things I have to remember

Sometimes I forget:

- ☐ to wipe, flush, and wash with soap
- ☐ what I was asked to do
- ☐ to brush ALL my teeth
- ☐ to use my lists
- ☐ that I should not hug people
- ☐ to finish my chores before I go out
- ☐ to wash my WHOLE body when I bathe
- ☐ other things: _____

Other

Phone Call Record Sheet

√	Date / Time	Person, Title, Organization	Phone Number / Fax
☐			

Notes:

√	Date / Time	Person, Title, Organization	Phone Number / Fax
☐			

Notes:

√	Date / Time	Person, Title, Organization	Phone Number / Fax
☐			

Notes:

√	Date / Time	Person, Title, Organization	Phone Number / Fax
☐			

Notes:

√	Date / Time	Person, Title, Organization	Phone Number / Fax
☐			

Notes:

Communication Between Preschool & Home

Name: _____

Date: _____

Class Schedule

Calendar Time	
Journal	
Language	
Numbers	
Theme	
Story Time	
Computer	

Music	**Art**
Gym	**Library**

Comments:

sand	**water**
listening	**blocks**
puzzles	**board games**
shelf toys	**book**

Communication Between Elementary School and Home

Name:	**Grade:**	**Date:**

Language Arts

Math / Arithmatic

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

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: _____ Team Leader: _____
name of child name of parent

Support Person/Recorder: _____
name, organization

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

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:

_____

_____