Get Acquainted Questionnaire

Date: _____

The safety of every child is very important to us. We want to ensure the best experience possible for your child. The information gathered from this questionnaire is confidential and will be shared only with those caring for your child. Please answer the questions below that apply to your child and that may help us best serve your child.

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

Telephone: _____ Email: _____

If you could choose three things you hope your child could experience in our care, what would they be?

_____

_____

_____

_____

Please describe your child's disability/diagnosis.

_____

_____

_____

_____

_____

_____

What are your child's interests and strengths?

_____

_____

_____

_____

_____

_____

Are there any behavioral challenges we should be aware of? [] Yes [] No

If yes, please describe and provide suggestions of how we may assist your child if these behaviors occur.

Are there events or "triggers" that may be emotionally challenging for your child? [] Yes [] No

If yes, please describe, and provide suggestions of how we may help your child manage the situation.

Which form of instruction best helps your child learn? [] Visual [] Auditory [] Kinesthetic [] Other

If other, please describe

If your child currently attends class in the community, would you describe the class setting as

[] a typical classroom (full inclusion) or

[] a self-contained classroom designed for children with disabilities.

Is there a certain behavior your child exhibits to communicate a specific need? [] Yes [] No

If yes, please describe.

Does your child need a sign language interpreter? [] Yes [] No

What kind of assistance will your child need in class?

Does your child need a “buddy” providing one-on-one supervision in class? [] Yes [] No

Does your child use any of the following?

[] Wheel chair [] Walker [] Noise Reduction Headphones [] Hearing Aids

[] Cane [] Crutches [] Communication Devices

Does your child have any medical conditions that the leaders need to be aware of? [] Yes [] No

Please explain. _____

_____

_____

_____

_____

_____

Does your child have seizures? [] Yes [] No If yes, how often? _____

_____

_____

If yes, what type of seizures? _____

_____

What triggers the seizures? _____

_____

Describe the protocol you wish us to follow should your child have a seizure under our care.

_____

_____

Does your child need assistance with eating a snack in class? [] Yes [] No

If yes, what kind of assistance? _____

_____

_____

Is your child allergic to anything, including food allergies? [] Yes [] No

If yes, what is the allergy and what is the reaction to the allergy?

_____

_____

Does your child carry an EpiPen? [] Yes [] No

Does your child need assistance with toileting? If yes, please explain. _____

If your child is age three or younger, may our volunteers change your child's diaper? [] Yes [] No
(Please request a pager at check-in if you have a child over age three with diapering needs.)

Is your child sensitive to loud music? [] Yes [] No
If yes, would he or she like to wear noise reduction headphones during the music time? [] Yes [] No

Does your child have any of the following sensory sensitivities? [] Light [] Tactile [] Odor [] Sound

Is there anything else you would like for us to know about your child?

_____ _____
Parent/Guardian Signature Date