

Confidential

**Special Family Weekend**  
**Child Care Information Form**

- ❖ Please be sure to complete a **separate form for each of your children** attending.
- ❖ **First time participants:** contact Lillian Leighton at 565-1030 for a brief over the phone interview about your child.
- ❖ Child Care will be provided during all workshops: Saturday morning & afternoon and Sunday morning.

**Child's name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Parent/Guardian name:** \_\_\_\_\_

**Phone #Day:** \_\_\_\_\_ **Evening:** \_\_\_\_\_ **email:** \_\_\_\_\_

**Siblings name(s) & date of birth:** \_\_\_\_\_

1. Special Needs?:  Yes  No **If yes: Diagnosis:** \_\_\_\_\_

2. Communication:  Verbal  Some words/phrases  Gestures  
 Picture Symbols  Sign Language  Non-verbal

3. Child's interests: \_\_\_\_\_

4. Medications: \_\_\_\_\_

5. Allergies: \_\_\_\_\_

6. Diet restrictions (regarding snacks): \_\_\_\_\_

7. Does your child show any of these behaviors? (please check all that apply)

<input type="checkbox"/> Hits or injures self or others	<input type="checkbox"/> Screams or shouts	<input type="checkbox"/> Tantrums
<input type="checkbox"/> Seems unaware of danger	<input type="checkbox"/> Doesn't respond to directions	<input type="checkbox"/> Wanders/runs away
<input type="checkbox"/> Other behavior difficulties?		<input type="checkbox"/> Gets over-stimulated easily

8. What are your child's toileting skills?  
 Diapers/Pull-ups  Will use bathroom when asked  Uses the bathroom by him/herself

9. What does your child dislike? \_\_\_\_\_

10. When your child is upset or over-stimulated, what helps him/her to calm down? \_\_\_\_\_

11. What else should providers know about your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(please feel free to copy this form as needed)