Child's Information

Section	Field/Check Box	
Identification	**Child's Name:**	
	Date of Birth:	
	Photo: (Attach a recent one)	
	Height/Weight:	
	Distinguishing Marks: (e.g., birthmarks)	
Disability/ Diagnosis	**Primary Diagnosis:**	
	Brief Description of Disability: (1-2 sentences)	
	Sensory Needs/Sensitivities: (e.g., loud noises, certain textures)	
Medical Contacts	**Primary Care Physician (Name/Phone):**	
	Specialist(s) (Name/Phone): (e.g., Neurologist, Cardiologist)	
	Emergency Contact (Not Parent/Guardian - Name/Phone):	
	Pharmacy (Name/Phone):	
Special Equipment	**Check all that apply:**	
	Wheelchair (Manual / Power)	
	Communication Device (e.g., AAC)	
	Ventilator / Respiratory Support	
	Feeding Tube (Type/Location)	
	Hearing Aids / Cochlear Implant	
	Detailed Operating Instructions for Equipment: (Attach separate sheet)	