My Child's Story

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Personal Information

Fill out the following information for your child and make updates as needed. You may wish to enter addresses and information in pencil so that it may be changed easily as needed.

Date of Birth:__________________

Place of Birth: ____

Date of Immigration: ____________________________________

Date Joined Family: _____________________________________

Language (s) Spoken: ____________________________________

Current Address: ____

Provincial Health Care Number: _________________________

Health Care Insurance Provider: ________________________

Health Care Plan Holder: __________________________________

Health Care Plan Number: _________________________________

Emergency Contact

Name: ____________________ **Home Number:** __________

Relation to child:_______________ **Cell Number:** ________

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Circle of Support

Family:

Name: ____________________ Home Number: __________________
Relation: __________________ Cell Number: ____________________

Name: ____________________ Home Number: __________________
Relation: __________________ Cell Number: ____________________

Name: ____________________ Home Number: __________________
Relation: __________________ Cell Number: ____________________

Name: ____________________ Home Number: __________________
Relation: __________________ Cell Number: ____________________

Name: ____________________ Home Number: __________________
Relation: __________________ Cell Number: ____________________

Name: ____________________ Home Number: __________________
Relation: __________________ Cell Number: ____________________

Friends:

Name: ____________________ Home Number: __________________

Name: ____________________ Home Number: __________________

Name: ____________________ Home Number: __________________

Name: ____________________ Home Number: __________________

Name: ____________________ Home Number: __________________

Name: ____________________ Home Number: __________________

Name: ____________________ Home Number: __________________

Community Connections:

Agency Name: ____________ Agency Number: ________________
Agency Contact (s): ____

Agency Name: ____________ Agency Number: ________________
Agency Contact (s): ____

Agency Name: ____________ Agency Number: ________________
Agency Contact (s): ____

Agency Name: ____________ Agency Number: ________________
Agency Contact (s): ____

Agency Name: ____________ Agency Number: ________________
Agency Contact (s): ____

Agency Name: ____________ Agency Number: ________________
Agency Contact (s): ____

Paid Support Workers

Workers Name: _________________ Agency: __________________
Home Number: _________________ Cell: ______________________

Workers Name: _________________ Agency: __________________
Home Number: _________________ Cell: ______________________

Workers Name: _________________ Agency: __________________
Home Number: _________________ Cell: ______________________

Workers Name: _________________ Agency: __________________
Home Number: _________________ Cell: ______________________

Workers Name: _________________ Agency: __________________
Home Number: _________________ Cell: ______________________

Workers Name: _________________ Agency: __________________
Home Number: _________________ Cell: ______________________

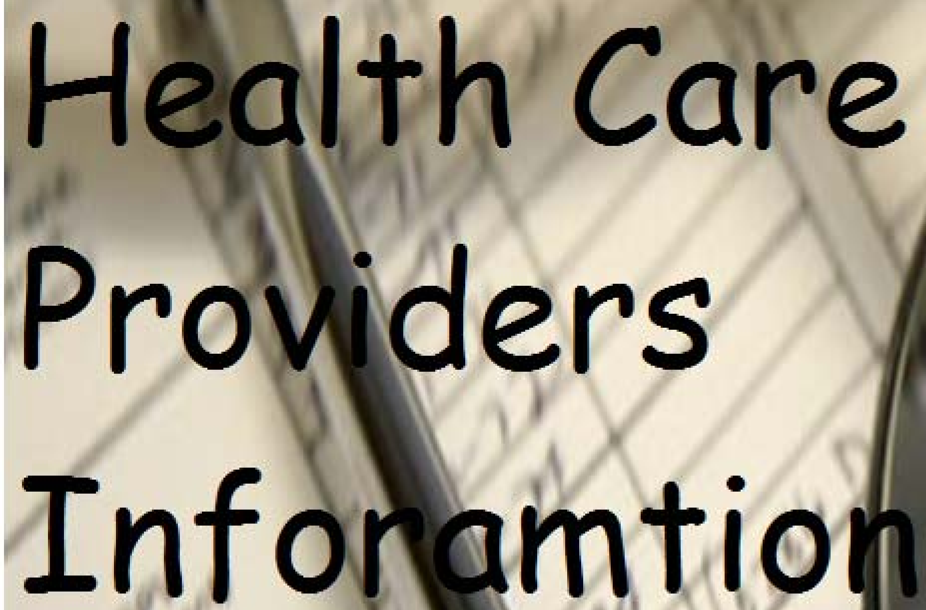
Community Resources

1. All About Autism	519-966-7283
2. Autism Services Incorporated	519-966-7283
3. Autism Society of Ontario	59-250-1893
4. Canadian Hearing Society	519-252-7241
5. Canadian Mental Health Association	519-255-7440
6. Canadian National Institute for the Blind	519-523-1900
7. Canadian Red Cross	519-944-8144
8. Centre for Addictions & Mental Health	519-251-0500
9. Children First (Children birth to 6 yrs)	519-250-1850
10. Children Horizons	519-686-4800
11. Community Living Essex County	519-776-6483
12. Community Living Windsor	519-974-4221
13. Easter Seal Society	519-944-0044
14. Ensemble (Family to Family Support)	519-776-6486 ext.225
15. Erie St. Clair Community Care Access Centre	519-258-8211
16. Family Respite Services	519-972-9688
17. Glengarda Child & Family Services	519-257-5106
18. Help Link	519-257-5437
19. Learning Disabilities of Windsor-Essex County	519-252-7889
20. Maryvale Child & Adolescent Services	519-258-0484
21. Ontario March of Dimes	519-972-9082
22. Summit Centre for Preschool Children with Autism	519-255-1195
23. The John McGivney Children Centre	519-252-7281
24. United Way of Windsor Essex-County	519-258-3033
25. Windsor-Essex Brokerage for Personal Supports	519-966-8094
26. Windsor-Essex Children's Aid Society	519-252-1171
27. Windsor-Essex County Health Unit	519-258-2146
28. Windsor-Essex Family Network	519-974-1008
29. Windsor Regional Children's Centre	519-257-5215

Hospitals

1. Hotel Dieu-Grace Hospital	519-973-4444
2. Leamington District Memorial Hospital	519-332-2501
3. Windsor Regional Hospital- Metroplitian Campus	519-254-1661

Health Care Providers Inforamtion



Physicians:

Name: ____________________ Specialty: _________________
Address: ____
Work Number: _____________ Cell Number: ______________
Fax: ______________________ Email: ____________________

Name: ____________________ Specialty: _________________
Address: ____
Work Number: _____________ Cell Number: ______________
Fax: ______________________ Email: ____________________

Name: ____________________ Specialty: _________________
Address: ____
Work Number: _____________ Cell Number: ______________
Fax: ______________________ Email: ____________________

Name: ____________________ Specialty: _________________
Address: ____
Work Number: _____________ Cell Number: ______________
Fax: ______________________ Email: ____________________

Name: ____________________ Specialty: _________________
Address: ____
Work Number: _____________ Cell Number: ______________
Fax: ______________________ Email: ____________________

Name: ____________________ Specialty: _________________
Address: ____
Work Number: _____________ Cell Number: ______________
Fax: ______________________ Email: ____________________

Physiotherapist

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Occupational Therapist

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Orthotics / Assistive Devices

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Speech / Language

Name: ___________________________
Address: ____
Work Number: _____________ Cell Number: _______________
Fax: _______________________ Email: ______________________

Name: ___________________________
Address: ____
Work Number: _____________ Cell Number: _______________
Fax: _______________________ Email: ______________________

Hearing

Name: ___________________________
Address: ____
Work Number: _____________ Cell Number: _______________
Fax: _______________________ Email: ______________________

Name: ___________________________
Address: ____
Work Number: _____________ Cell Number: _______________
Fax: _______________________ Email: ______________________

Vision

Name: ___________________________
Address: ____
Work Number: _____________ Cell Number: _______________
Fax: _______________________ Email: ______________________

Name: ___________________________
Address: ____
Work Number: _____________ Cell Number: _______________
Fax: _______________________ Email: ______________________

Social Worker

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Psychologist

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Dentist

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Name: ___________________________
Address: ____
Work Number: ______________ Cell Number: _______________
Fax: ________________________ Email: ______________________

Medical

Profile

Allergies

Allergy To…	Life Threatening Yes/No	EpiPen Yes/No	What should be done?

Blood Type: ________________________________

Other Health Concerns

Respiratory Illness
Does your child suffer from a respiratory distress disease? Yes / No
Frequency of Attacks? ____
What are the triggers of the attacks? ________________________________
____
What medications does your child take for the attacks? ____________
____
____

Vision
Has your child's vision been tested by his/her doctor?
Yes / No
Has your child's vision been tested by a specialist? Yes / No
Does your child wear protective lenses? Yes / No
Has your Child ever been tested for Visual Perception difficulties?
Yes / No

If Yes, Details: ____

Can your child distinguish colors? Yes / No

Hearing
Has your child's hearing been tested by a doctor? Yes / No
Has your child's hearing been tested by an audiologist?
Yes / No
Does you child wear corrective devices? Yes / No

Has your child been tested for auditory perception difficulties?
Yes / No
If yes, details: ____

Speech and Language
As your child had a speech and language assessment?
Yes / No
If yes, details: ____

Has everyone ever said that your child does not speak clearly?
Yes / No

Record of Immunizations

Age	Diphtheria	Pertussis (Whooping Cough)	Tetanus	Polio	Hib	Measles	Mumps	Rubella (German Measles)	Pneumo conj. (Prevnar)	Men C. Conj.	Varicella (chicken pox)	Hepatitis B	Influenza (flu)	**Administered by:** (Physician Name & Phone #)
	1 Shot					1 Shot (MMR)								
2 months														
4 months														
6 months														
after 6 months													Every autumn	
12 months														
15 months														
18 months														
4 - 6 years														
12 years														
14 - 16 years														
Adult (every 10yrs)														

Other Immunizations	
Date	Vaccine

Tuberculosis			
BCG	TB Skin Test Result		
Date	Date	Size (M)	Interpretation (Pos/Neg)

Family Medical History

Name: ____________________ Relation: __________________
Medical Information: ____
____

Name: ____________________ Relation: __________________
Medical Information: ____
____

Name: ____________________ Relation: __________________
Medical Information: ____
____

Name: ____________________ Relation: __________________
Medical Information: ____
____

Name: ____________________ Relation: __________________
Medical Information: ____
____

Current Medical Information

Name of Medication	Dosage	Prescribing Physician	Start Date	End Date

Evaluations of Medication

Name of Medication: ________________
Dosage: ____

Time(s) Taken: ____

Special Instructions: ____

____

Reason for Taking: ____

____

Effects: ____

Side Effects: ____

Effects on other Medication: __________________________________

Consequences of not taking: __________________________________

Alternatives: ____

Start Date/ End Date: ____

Reason for Discontinuing the Medication: ______________________

Name of Medication: ________________

Dosage: ____

Time(s) Taken: ____

Special Instructions: ____

____

Reason for Taking: ____

____

Effects: ____

Side Effects: ____

Effects on other Medication: __________________________________

Consequences of not taking: __________________________________

Alternatives: ____

Start Date/ End Date: ____

Reason for Discontinuing the Medication: ______________________

Hospital Visits Sheet

Date	Doctor seen by	Test	Diagnosis	Outcome/ Medication given

Sickness & Injury

Date/Duration	Diagnosis	Tests & Medication	Physician(s)

Surgery Chart

Date/Duration	Reason for Surgery	Test & Medications	Physician (s)	Recovery Time

Medical Testing

Date	Test	Physician	Results

Family
Changes

Changes within the Family

Note any significant changes or series of events that have happened within or close to the family.

Parents: ____
____
____
____
____

Guardians: ____
____
____
____
____

Siblings: ____
____
____
____
____

Grandparents: ____
____
____
____
____

Relatives: ____
____
____
____
____

Friends / Classmates: ____

____

____

____

____

Teachers: ____

____

____

____

____

Pet: ____

____

____

____

____

Home: ____

____

____

____

____

Others:____

____

____

____

____

Height & Weight Chart

Gestational Birth Age: ______________ ___________

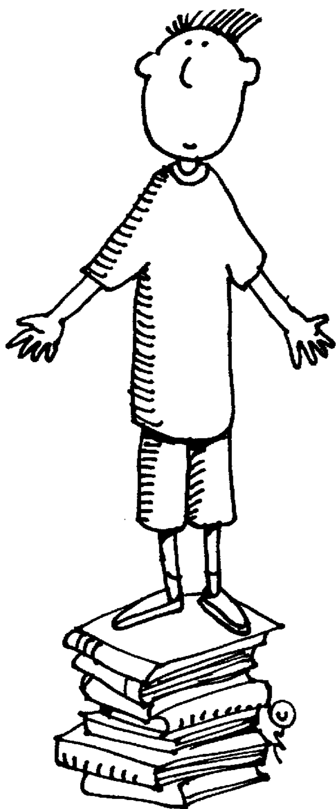
Weeks Days

Birthday: ______ _____ _____

Year Month Day

Child's Birth Weight: __________

Child's Birth Length: __________



Age	Date	Weight	Height
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

Your Child's Learning Milestones

At what age did your child first…

…have someone read to them?

…try to read by himself/herself?

…recognize different colors?

…draw a person with 3 body features?

…try to draw?

…try to write?

…copy simple shapes without tracing?

…use scissors properly?

…recognize letters?

…copy letters?

…start counting?

…recognize numbers?

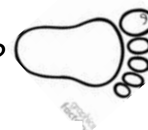
…copy numbers?

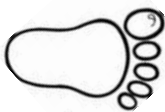
…cut paper along a line?

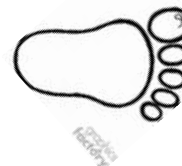
Physical Milestones:

At what age did your child…

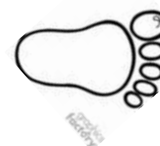
Stand in place with help?

Stand up by himself/herself? 

Start to walk? 

Climb stairs? 

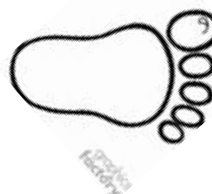
Start to talk?

Drink from a cup? 

Feed himself/herself with fork/spoon?

Show independence with dressing?

Start to unbutton buttons?

Start washing hands using soap and a towel? 

Special Memories

My child is the funniest when they…

____
____
____

My child enjoys …

____
____
____

My child likes going to…

____
____
____

My child's favorite activity is…

____
____
____

School
Experience

Child Care & School Enrollments

List all child care centers and schools that your child has attended, no matter how briefly. Also include all other learning opportunities

Start Date	End Date	Name of Institution	Address	Phone Number / Contact Name	Reason for Transfer

Determine Your Child's Learning Style

Just as all children have different personalities, they also have different learning styles. Children begin to show their individual learning strengths as early as age 3. There are three different learning styles that have been recognized. These are visual, auditory and kinesthetic. The more opportunities that children have to gather information in their preferred style, the more successful they will be in school. Check off those that apply to your child

The Visual Learner

Does your child …

- □ Learn by watching
- □ Benefit from the use of pictures
- □ Enjoy art and drawing
- □ Like puzzles
- □ Prefer books with pictures
- □ Daydream often
- □ Get distracted by untidiness or movement
- □ Forget names, but remember faces
- □ Learn best when shown how to do something
- □ Prefer teachers who use a board or chart paper to write things down
- □ Draw diagrams or pictures to problem solve
- □ Notice details
- □ Notice similarities and details
- □ Have good hand / eye coordination
- □ Have a vivid imagination
- □ Have trouble remembering verbal instructions

The Auditory Learner

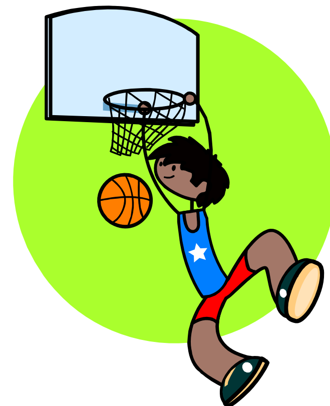
Does your child …

- □ Learn best by listening
- □ Learn best by listening
- □ Remember things easily when sung a song
- □ Have difficulty reading
- □ Enjoy listening to others
- □ Remember names but forget faces

□ Like talking on the phone
□ Enjoy music
□ Enjoy reading out loud
□ Give directions verbally
□ Prefer people who speak with expression
□ Have a difficult time concentrating when in a noisy room
□ Talk through problems
□ Like to tell stories and jokes
□ Like to play work games
□ Talk to him/herself
□ Hum
□ Ask a lot of questions
□ Make a lot of noise if it is too quiet
□ Love to talk about what he/she is doing.

The Kinesthetic Learner (hands-on)

Does your child …



□ Like to find out how things work
□ Learn through skits and role plays
□ Have difficulty sitting for long periods of time
□ Like action books and movies
□ Try things impulsively
□ Have a short attention span
□Fidget a lot
□ Point or move while giving directions
□ Prefer teachers who give hands on activities
□ Try to put things together without instructions
□ Uses a lot of gestures
□ Becomes bored easily
□Show you things rather than tell you about them
□ Have a difficult time learning in a traditional school setting
□ Learn best when trying to do an activity alone

Tips for Different Learning Styles

If your child is a visual learner …	***If your child is an auditory learner…***
❖ Draw pictures symbols ❖ Use flash cards ❖ Write things in colour ❖ Highlight important words ❖ Create charts or diagrams.	❖ Turn instructions or information into songs ❖ Read out loud together ❖ Encourage him/her to repeat instructions out loud ❖ Talk out problems and solutions ❖ Write out sequences and then read them out loud.
If your child is a kinesthetic learner (hands-on)…	**What to consider regardless of your child's learning personality**
❖ Let your child fidget while listening ❖ Limit instruction time to 10 minutes ❖ Allow your child to take frequent breaks ❖ Combine instructions with physical activities such as clapping or jumping when counting ❖ Teach by taking on field trips ❖ Create skits or plays.	❖ Keep your expectations realistic ❖ Help your child at home ❖ Approach your child's teacher with ideas on how to support your child's learning style ❖ Teach your child coping skills for activities that aren't geared towards his/her learning style

Reports &

Recommendations

Professional Involvement

Name	Specialty	Address/Phone Number	Reason for Consultation	Start Date	End Date

Type of Intervention: ______________________________

Is this intervention…

…a new introduction? Yes / No

…a discontinuation? Yes / No

…a change? Yes / No

… a reintroduction? Yes / No

What other interventions are being introduced? _______________
____
____
____
____

Date: _______________ Frequency: ____________________

Observations: ____
____
____
____
____
____
____
____
____
____
____
____

Report Log

Date of Documentation	Author of Documentation	Description of Documentation

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