Child’s name: Age: DOB:

Address:

Your phone: Cell Phone:

Neighbor/close by family contact:

Medications (and how/when to give them):

Toileting:

Eating:

Bathing behaviors/activities:

Bedtime behaviors/habits. Does she/he awaken often? Leave the room/stay in the room?:

Autism Spectrum Disorder:

 Cognitive abilities:

 Verbal abilities. Do you use pictures/signs/I should know?:

 Social interactions:

 Physical limitations:

 Environmental (sensitivity to light, sound touch, etc.):

 Restrictive interests:

 Repetitive interests:

 Words or actions that calm:

 Words or actions that cause distress:

 How should I handle meltdowns?:

Please describe the unique, individual qualities of your child that will help in providing loving, enjoyable, optimal care. Are there favorite books, music or interests? Favorite activities and play? Games? Does she/he like to hear singing? Is it okay to go outside? Anything else I should know?

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