
(paste a picture of your child here)

My Information Binder

Section I - Information about me

My first name is _____

My last name is _____

I was born on _____
 month day year

My address is _____

My telephone number is (_____) _____

_____ is my mother / father / guardian.

_____ is my mother / father / guardian.

In case of emergency please contact:

Name: _____ Relationship _____

Telephone _____ (or) _____

Name: _____ Relationship _____

Telephone _____ (or) _____

I am allergic to _____

Section 2 - **Medical information**

I have the following medical conditions:

- Seizures
- Asthma
- Heart condition
- Diabetes
- Seasonal allergies _____
- Food allergies _____
- Other _____

I use the following medical equipment:

- Wheelchair
- Walker
- Leg splint / brace
- Seating support
- G-tube
- Glasses
- Hearing aid(s)
- Other _____

I take the following medication (please list):

Drug Name	Time	Dose

VISION

I have the following condition with my eye sight:

- difficulty with depth perception
- legally blind
- vision in one eye only _____
- strabismus (sometimes called “lazy eye”)
- other _____

It is hard for me to see things that are:

- up close
- far away
- both

I see best when I:

- sit at the front of the classroom
- wear my glasses
- wear a patch over one eye

HEARING

I have the following conditions that affect my hearing:

- frequent ear infections
- tubes in my ears
- hearing loss
- other _____

It is hard for me to hear:

- quiet sounds (e.g., whisper)
- low pitch tones (low voice)
- high pitch tones (kettle, school bell)
- there are no distractions
- other _____

I hear best when:

- sound is directed to my right ear
- sound is directed to my left ear
- I am wearing my hearing aid(s)
- there are no distractions
- other _____

I communicate by:

- speaking a few words
- speaking many words
- using pictures (may include Picture Exchange Communication System)
- using objects
- using sign language
- using Braille

- I speak a language other than English _____
- I understand a language other than English _____

I can understand when:

- people give me one-step instructions (e.g., sit down)
- people give me two-step instructions (e.g., get coat and put on)

You can help me understand you by:

- speaking loudly
- speaking slowly
- looking at me when you want to show, or tell me something
- giving me time to answer
- repeating words, or gestures
- moving slowly when you want to show me something
- other _____

Smell:

I like the smell of _____

I don't like the smell of _____

Taste:

I like to eat _____

I don't like to eat _____

Touch:

I like the feel of _____

I don't like the feel of _____

Sound:

These noises/sounds comfort me _____

These noise/sounds bother me _____

Visual:

I like to look at _____

I don't like to look at _____

Movement:

I enjoy (e.g., swinging, rocking) _____

I don't enjoy _____

I get upset when:

- I can't have my way
- someone hurts me
- I have to stop playing
- other _____

When I get upset I:

- hit
- scream
- want to be by myself
- other _____

You can help me by:

- giving me time to calm down
- giving me a choice
- letting me know when something will change
- other _____

When I do a good job I like:

- verbal praise
- songs
- stickers
- a special treat _____
- other _____

WASHROOM

I can use the washroom: by myself need help to _____

When I need to use the washroom I tell you by:

I need help to change my diaper: yes no

I usually need to use the washroom when _____

DRESSING

I can put clothing on by myself I can take clothing off by myself

I need some help to _____

I can fasten and unfasten these by myself:

zippers snaps

buttons

I can put my coat on by myself

I need some help to _____

I can put my shoes on by myself

I need some help to _____

I like to wear _____

I don't like to wear _____

MEALTIME

I let you know when I'm hungry by: _____

- I can eat by myself
- I need some help to _____

- I can drink by myself
- I need some help to _____

I use special utensils to eat:

- straw
- easy grip spoon
- divided plate
- other _____

My favourite foods are _____

I don't like to eat _____

SLEEP

When I am tired I _____

I sleep best when:

- | | |
|---|---|
| <input type="checkbox"/> I have my stuffed toy | <input type="checkbox"/> it is quiet |
| <input type="checkbox"/> there is light in the room | <input type="checkbox"/> I have a blanket |
| <input type="checkbox"/> the room is dark | <input type="checkbox"/> someone sits with me until I fall asleep |
| <input type="checkbox"/> there is relaxing music | <input type="checkbox"/> other _____ |

I usually sleep for _____ **hours at a time.**

I usually go to bed at _____ **and wake up at** _____ **in the morning.**

I take a nap at _____

I like to sleep with _____

FAVOURITE ACTIVITIES

I like spending time with these people _____

I like spending time alone

At home I like to:

- | | |
|--|--|
| <input type="checkbox"/> watch tv | <input type="checkbox"/> ride my bike |
| <input type="checkbox"/> play videos games | <input type="checkbox"/> listen to music |
| <input type="checkbox"/> other _____ | |

At school I like to:

- | | | |
|--|---|--|
| <input type="checkbox"/> go to the library | <input type="checkbox"/> play at recess | <input type="checkbox"/> work in a group |
| <input type="checkbox"/> go to gym class | <input type="checkbox"/> other _____ | |

At child care I like to:

- | | | |
|--------------------------------|--------------------------------------|--|
| <input type="checkbox"/> play | <input type="checkbox"/> do puzzles | <input type="checkbox"/> build with blocks |
| <input type="checkbox"/> paint | <input type="checkbox"/> other _____ | |

In the community I like to:

- | | | |
|---|--|--|
| <input type="checkbox"/> go swimming | <input type="checkbox"/> go to dance class | <input type="checkbox"/> go horseback riding |
| <input type="checkbox"/> go to the park | <input type="checkbox"/> other _____ | |

I also like to _____

I don't like to _____

- I like to try new things I like to do the same things

My favourite toy is _____

I am learning how to _____

Section 9 - Service Providers

Service:

Agency name:

Contact:

Phone: _____ **Email:** _____

Address: _____

Service:

Agency name:

Contact:

Phone: _____ **Email:** _____

Address: _____

Section 9 - Service Providers

Service:

Agency name:

Contact:

Phone: _____ **Email:** _____

Address: _____

Service:

Agency name:

Contact:

Phone: _____ **Email:** _____

Address: _____

Section 9 - Service Providers

Service:

Agency name:

Contact:

Phone: _____ **Email:** _____

Address: _____

Service:

Agency name:

Contact:

Phone: _____ **Email:** _____

Address: _____
