

**SCHOOL AGE CHILD DATA INFORMATION**

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| Child’s Name: | D.O.B:   /  / | Today’s Date:   /  / |

**Dietary & Medical Information**

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| Please list any allergies and\or dietary restrictions your child has: |
| Does your child require an Epi-Pen to treat a reaction to any allergies? |
| Is your child on regular medication? If so please list. |
| **Please list some of your child’s dietary likes and dislikes:** |
| Likes: |
| Dislikes: |

**Toilet Habits**

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| If accidents occur how frequently & what time of day do they usually happen? |
| Do you have any concerns about your child’s toileting habits? If yes please describe: |

**Developmental History**

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| Were there any pregnancy or birth difficulties with this child? If yes, please describe |
| Do you have any concerns with your child’s development: |
| Did\Does your child receive support services (OT, PT, Speech\language). If so please describe. |

**Miscellaneous Information**

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| How does your child relate to strangers? | | | |
| Please describe any particular habits, fears, or mannerisms your child displays. | | | |
| Does your child have words\nicknames for things and\or caregivers we might not be able to understand or figure out? | | | |
| **What are your Child’s Favorite…..** | | | |
| Toys | Books | People | School Subjects |
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**Family Information**

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| Who does your child live with? (Please include people in the household, living arrangements and custody agreements. If the child alternates between households, please explain) |
| Have there been any difficulties or crises in your family such as divorce, death, legal issues or medical problems that may have emotionally affected your child? If yes, please describe: |

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| Please include any other information you would like us to know about your child: |