THE LEARNING LAB
YOUTH DEVELOPMENT CENTER

Student Profile

Child's Name: _____

Program/ Class: _____

"Getting to Know You or Meet and Greet" Date: _____

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Dear Parents,

Welcome to TLL! In order to better understand your child, we have designed this booklet to allow you to share information concerning your child's personal habits, skills, and health. This profile will give us a "head start" in attaining our goal of meeting your child's needs. Feel free to include any additional information and concerns.

GENERAL INFORMATION

Child's Full Name: _____

Nickname: _____

Birthdate: _____

Age: _____

Parent Names: _____

If child is not in care of parents, please list guardian name(s):

_____

What is the marital status of parents?

Married ☐ Divorced ☐ Separated ☐ Single ☐

Are both parents living in the house with the child? Yes No

_____

Please list all siblings:

_____

Name Age

_____

_____

_____

Please list anyone else living in the house with the child:

_____

Name Relationship

_____

_____

_____

Who will be dropping off your child?

_____

Who will be picking up your child?

SELF HELP SKILLS

Dressing

Please describe your child's dressing habits and need for assistance:

Toileting

Please describe your child's toileting habits and need for assistance:

What words does your child use to communicate toileting needs?

PLAY SKILLS

What does your child enjoy doing/playing?

How does your child get along with other children?

COMMUNICATION SKILLS

How does your child express his or her needs? _____

_____

_____

Can you understand your child's speech? ☐ Yes ☐ No

Can others understand your child's speech? ☐ Yes ☐ No

Comments: _____

_____

_____

Please list any unusual words that your child uses to communicate: _____

_____

_____

_____

Please describe how your child listens and follows directions: _____

_____

_____

What language does your child and family speak? _____

PERSONAL CHARACTERISTICS

Circle the characteristics that seem to describe your child:

Tense Sad Happy Sensitive Creative Relaxed
Outgoing Energetic Caring Quiet Frustrated
Demanding Stubborn Cooperative

Is your child:
Right-Handed Left-Handed Undetermined

How does your child generally react to new experiences?

_____

_____

_____

_____

Does your child have any unusual fears?

_____

_____

How does your child react to a frustrating situation?

_____

_____

_____

_____

MEDICAL INFORMATION

Please provide information if your child has a history of any of the following conditions:

Date Circumstances

Allergy _____

Asthma _____

Concussion _____

Convulsions _____

High Fevers _____

Seizures _____

Serious Falls _____

Serious Injury _____

Chronic Illness _____

Hospitalization _____

Other _____

Describe any history of visual problems:

_____

_____

Does your child wear glasses? Yes ☐ No ☐

If yes, please explain:

_____

_____

Describe any history of hearing problems:

_____

_____

Medication

Please list your child's current medication(s):

Please list the condition(s) that the medication(s) treat:

Please list any other current medical issues:

How would you describe your child's general health?

Please describe any physical handicaps or limitations:

Please describe any special dietary needs and/or food allergies:

Are there any special concerns that we need to know?

Are any early intervention services provided for your child? If yes, please describe:
(Please provide your center director with IFSP or IEP documentation if applicable.)

Please describe any helpful hints that will enable us to best work with your child: