ABOUT ME

name child prefers to be called m	onth/year of this update

insert child's

current photo

VISION STATEMENT

Include 3-4 sentences about your vision for your child's life, their needs, how your family and your child's providers can best support them, and how they can be part of their community.

MY CHILD'S STRENGTHS

Tell us about any recent milestones (i.e., physical, speech, or development-related) that your child has achieved, activities your child prefers to do and areas in which they excel.

WHAT MY CHILD IS CURRENTLY WORKING ON

Share a list of current physical, speech-related, developmental or behavioral goals you are currently working on with your child.

WHAT WORKS WELL FOR MY CHILD

Detail approaches that work best with your child when they become frustrated, how best to model appropriate responses/behavior, and ways to establish healthy interactions with your child.

WHAT DOES NOT WORK FOR MY CHILD

Share what frustrates or upsets your child, including seemingly minor things like approaching them too quickly, getting too close or talking too much.



MY HEALTHCARE PROVIDERS

child's legal name	
name child prefers to be called	month/year of this update

Please use this page to list:

- Therapy or service your child receives (i.e., Trisomy 21 Program, pediatrician, speech, OT, PT, nutrition, allergy, cardiac, etc.)
- Name of the person/agency performing the service (include credentials when possible)
- Frequency of the service (i.e., 1x a week, 2x a year)
- Date of last and/or next visit
- Notes, concerns and goals of therapy/service

Copy this page if additional services are provided to your child.

THERAPY/ SERVICE RECEIVED	PERSONNEL (name & credentials)	FREQUENCY (x per week, month, year)	DATE OF LAST VISIT (LV) OR NEXT VISIT (NV) (please specify)	NOTES, CONCERNS & GOALS
Example: ENT	Bob Smith, MD	3x/year	LV: July 1 NV: Nov. 1	Ears looked good, no fluid, keep up ear drops, follow up with Audiology

MY DAILY SCHEDULE

child's legal name	
name child prefers to be called	month/year of this update
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Please use this page to list your child's daily schedule including wake and sleep times, meals, snacks, activities, medications, and any notes about this time in their typical day. Copy this page if additional details are needed about your child's daily schedule.

TIME	ACTIVITY	FOOD & DRINK (type and quantity)	MEDICATIONS (type and dosage)	SPECIAL NOTES
Example: 7 a.m.	Wake up	Sip of water; then nothing until breakfast.	Synthroid (M-Th 44mg, F-Su 37.5mg)	typically sleeps 9 hours and wakes in good mood