

All About Me



RESPITE4U AGENCY

All About Me

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All About Me

This is Me

My name is _____

I am _____ years old. My birthday is on ____/____/____

(dd/mm/yy)

The school I go to is: _____.

I am in grade ; _____.

My teacher's name is _____

My favourite people and things are (for example, friends, pets, books, toys):

My favourite places are (for example, home, park, community centre):

Paste picture here

My Picture

All About Me

This Is My Family

These are the names of all the people who live in my home:

My Mom's name is _____

My Dad's name is _____

I have _____ brother(s) and these are their names:

I have _____ sister(s) and these are their names:

Other people who live with me:

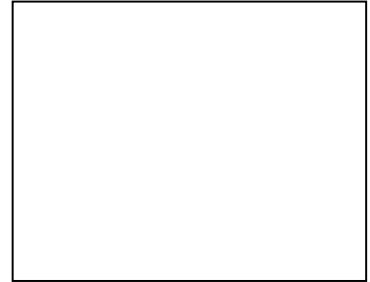
Names: _____

My phone number is: _____

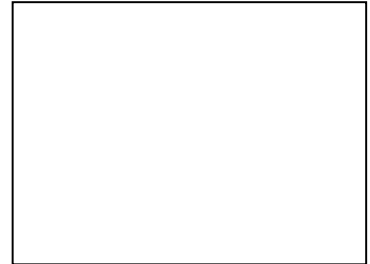
My address is: _____

And this is how you get there:

my family and friends
(pictures if available)



people in photo: _____



people in photo: _____



people in photo: _____

All About Me

Emergency & Medical Contacts

Parents/Guardians/Caregivers: Home #: _____ Work #: _____ Cell #: _____
Parents/Guardians/Caregivers: Home #: _____ Work #: _____ Cell #: _____

Person(s) to be called in an emergency: (relationship)

1. _____ (name)	2. _____ (name)	3. _____ (name)
_____	_____	_____
(relationship)	(relationship)	(relationship)
_____	_____	_____
(contact #)	(contact #)	(contact #)

Health Card #: _____

Family Doctor's Name: _____ Phone #: _____

Family Dentist's Name: _____ Phone #: _____

Specialists: 1. _____
(name and contact #)
2. _____
(name and contact #)
3. _____
(name and contact #)

Pharmacy Name: _____ Phone #: _____

9-1-1- service is available in my area: Yes No (please circle)

If not, please list:

Hospital Preferred: _____ Phone #: _____

Ambulance #: _____ Poison Control Centre: _____

Police: _____ Fire: _____

Other Agencies Involved In The Care Of The Child:

Agency	Contact Person	Phone #:
i) _____	_____	_____
ii) _____	_____	_____
iii) _____	_____	_____
iv) _____	_____	_____

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Medical Information

My _____ tells me that my diagnosis is _____
(parent/doctor)

Medications:

Name of Medication	Dosage	When it should be taken i.e., before, after or with meal	Reason I take it
--------------------	--------	---	------------------

I require support in taking my medication: Yes No

My medication is usually taken by _____

I prefer my medication to be _____
(crushed, with juice, etc.)

Special instructions/ precautions for giving medications to me: _____

I am allergic to: _____
(medication, food, environmental)

Please explain: _____

All About Me

More Medical Information About Me

Date of my last doctor's appointment: _____

My immunization is up to date: Yes No

My Vision: _____

My Hearing: _____

My Mobility: _____

My Respiratory: _____

My Skin Care: _____

I experience seizures: Yes No

Seizures: (explain in detail, frequency, etc.)

Absence (Petit Mal): _____

Tonic-Clonic (Grand Mal): _____

Complex-Partial (Psycho Motor): _____

The support I require during and following a seizure is: _____

Other medical information you should know about me:

(conditions, contagious diseases, equipment, supplies, support needs)

All About Me

Communication

I communicate:

Method	always	sometimes	never	Comments
by using words:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
by using signs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
by using bliss/PECS:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
by using gestures/ facial expressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

More information about how I communicate: _____

If I need or want something, I will let you know by: _____

My special words, signs, gestures are: _____

When you are communicating with me, I need you to:

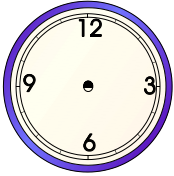
Method	always	sometimes	never	Comments
Make eye contact:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use smaller sentences:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Control your tone of voice:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use gestures/facial expressions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use signs/PECS/bliss:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other information: _____

All About Me

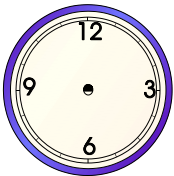
I Like to Eat

Breakfast: Foods: _____



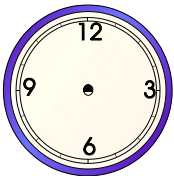
Time: _____

Lunch: Foods: _____



Time: _____

Dinner: Foods: _____



Time: _____

Snacks: Times: _____ Types: _____

My favourite treats are: _____

I need assistance to eat: Yes No

You can help me eat by: _____

I need special equipment to eat: Yes No

Details: _____

All About Me

I Like to Eat

Some foods I eat require special preparation. (i.e. mashed, pureed, cut up finely)

Length of time it takes me to eat _____

I _____ prone to choking spells.

am/am not

Foods I should not eat _____

BEVERAGES I LIKE: I need to use a straw: Yes No

Milk _____ Juice _____ Coffee _____

Chocolate Milk _____ Pop _____ Tea _____

Hot Chocolate _____ Water _____ Other _____

SNACK FOOD I CAN HAVE:

Potato Chips _____ Raisins _____ Ice Cream _____ Yogourt _____

Cookies _____ Nuts _____ Pudding _____ Fruit _____

Candy _____ Crackers _____ Jello _____ Gum _____

Cereal _____ Cheese _____ Apple Sauce _____ Chocolate _____

Other _____

All About Me



Bedtime

My usual time for bed is _____, and I wake up at _____ in the morning.

I _____ wake up at night.
always/sometimes/almost never/never

If I do wake up it is usually for _____

I _____ assistance during the night.
require/do not require

When I do require assistance it will be for _____

I _____ repositioning during the night.
need/do not need

I sleep in a _____.
bed/crib/bed with rails

I like to have my bedroom door _____ and the light _____.
open/shut on/off

I _____ wet the bed.
sometimes/never

Other helpful things to know, (number of blankets, pillows, nightlight, toys, etc):

All About Me

My Daily Life

When I'm getting dressed, I can do everything on my own: Yes No

You can help me by: _____

When I need to go to the bathroom I will:

Go by myself: Yes No

Let you know by: _____

Need your assistance with: _____

I wear: underwear diapers Pull ups briefs

And extras can be found: _____

When it comes to personal hygiene, I am totally independent: Yes No

I need some help:

Bathing: Yes No Comments: _____

Washing hands and face: Yes No Comments: _____

Brushing teeth: Yes No Comments: _____

Combing/Brushing hair: Yes No Comments: _____

Feminine Hygiene: Yes No Comments: _____

Other: Yes No Comments: _____

During the day I like to have a rest/nap: Yes No

Time: _____

Place: _____

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My Recreation Activities

My favourite toys/games are: _____

My favourite activities are: _____

My favourite sports are: _____

My favourite places to go are: _____

My favourite people to get together with are: _____

My favourite T.V. programs are: _____

It is preferred that I not watch: _____

Other things I enjoy: _____

All About Me

Feelings

The things that make me happy are: _____

The things that make me sad are:

The things that make me upset/angry are: _____

Sometimes I am afraid _____

You can help me with this by _____

All About Me

A Day In My Life Looks Like This:

6:30 _____

7:00 _____

7:30 _____

8:00 _____

8:30 _____

9:00 _____

10:00 _____

10:30 _____

11:00 _____

12:00 _____

1:00 _____

1:30 _____

2:00 _____

2:30 _____

3:00 _____

3:30 _____

4:00 _____

4:30 _____

5:00 _____

5:30 _____

6:00 _____

6:30 _____

7:00 _____

7:30 _____

8:00 _____

8:30 _____

9:00 _____

9:30 _____

10:00 _____

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