**Right At H****me Preschool**

**Special Needs Questionnaire**

Completion of this form allows us to determine if any specialized care is needed while your child is attending our program. Depending on your child’s needs, additional paperwork and an assessment meeting with the staff may be required prior to your child’s start date. This is to ensure that the best accommodations are provided. Failure to give detailed information identifying such causes for any special care, accommodations or supervision, may jeopardize the placement of or continued service for your child. Complete each section to the best of your knowledge. Place “N/A” (Not Applicable) in any section that does not pertain to your child’s current state of physical, developmental, social or mental health.

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any difficulty feeding him/her self? Yes No

 Yes No

 Yes No

What age did your child being walking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your child start to speak words?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child fully potty trained? Yes No

 Yes No

 Yes No

If yes, what age was your child when s/he became fully potty trained? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child need help while using the bathroom? Yes No

 Yes No

 Yes No

Does your child dress him/her self properly? Yes No

 Yes No

 Yes No

Does your child have any health, physical, developmental, social or mental special needs?  Yes No

 Yes No

If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child have any allergies – including drug and food sensitivities? Yes No

 Yes No

 Yes No

If yes, please list:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosed by a physician? Yes No Year detected: \_\_\_\_\_\_

 Yes No

 Yes No

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosed by a physician? Yes No Year detected: \_\_\_\_\_\_

 Yes No

 Yes No

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosed by a physician? Yes No Year detected: \_\_\_\_\_\_

 Yes No

 Yes No

Complete this section for any emergency medication or device that will need to be contained at preschool. Check all that is needed:

 Epi Pen Epi Pen with Benadryl Benadryl Inhaler Nebulizer Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No

 Yes No

 Yes No

 Yes No

 Yes No

 Yes No

Is your child under the care of a physician for any condition? Yes No If yes, name condition:

 Yes No

 Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any challenges with motor skills, vision, or cognitive skills? Yes No

 Yes No

 Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child require any specialized medical or safety equipment to be used any time during the day?

 Yes No If yes, name equipment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No

 Yes No

How often is the equipment used during the daytime?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child receive any specialized services? (Ie. One – on – one Para; physical therapy; speech therapy; Occupational therapy; Nursing service) Yes No If yes, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No

 Yes No

If yes, name the program or individuals who provide the service. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete this section is your child has any of the following disorders? Check all that apply:

 Attention – Deficit/Hyperactivity Disorder (ADHD)

 Autism Spectrum Disorder (ASD) What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Anxiety Disorder What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mood Disorder What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about your child’s health that you have NOT spoken with a specialist about?

 Yes No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No

 Yes No

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Parent/Guardian Signature Date