

# Handout #10 LET ME TELL YOU ABOUT MY CHILD SERIES

## For Children From Birth To Five Years Of Age

While you are working to bring your family together, help your caseworker and your child's foster caregiver know about your child. The information you provide will help those caring for your child. With your caseworker's assistance, share as much information as you know when you first meet.

This form does not include everything. Continue to work with the caseworker and caregiver by tell them what is special about your child. Add information that helps them understand what your child needs.

**My child's name is** \_\_\_\_\_ **My child's nickname is** \_\_\_\_\_  
**Age** \_\_\_\_\_ **Birthday** \_\_\_\_\_

### Sleeping: My child

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> goes to bed at _____      | <input type="checkbox"/> goes to bed easily                                 | <input type="checkbox"/> stays up; reads, playing on computer; watches TV                             |
| <input type="checkbox"/> sleeps alone              | <input type="checkbox"/> shares bed/r room with another child               | <input type="checkbox"/> sleeps in separate room <input type="checkbox"/> with an adult family member |
| <input type="checkbox"/> sleeps through the night  | <input type="checkbox"/> wakes up often during the night                    | <input type="checkbox"/> has nightmares <input type="checkbox"/> sometimes wets the bed               |
| <input type="checkbox"/> needs help going to sleep | <input type="checkbox"/> likes me to stay in room                           | <input type="checkbox"/> goes to sleep without help from an adult                                     |
| <input type="checkbox"/> likes a snack before bed  | <input type="checkbox"/> likes an activity before bed such as reading _____ |   |
| <input type="checkbox"/> sleeps with a nightlight  | <input type="checkbox"/> sleeps with a favorite toy or blanket _____        |   |

Comments: \_\_\_\_\_

### Waking: My child

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> wakes up easily        | <input type="checkbox"/> wakes up around _____               | <input type="checkbox"/> has difficulty waking up           |
| <input type="checkbox"/> likes to eat breakfast | <input type="checkbox"/> does not like to eat in the morning | <input type="checkbox"/> has a difficult time getting going |

Comments: \_\_\_\_\_

### Bathing, Grooming and Dressing: My child

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> needs assistance to take a bath                                       | <input type="checkbox"/> bathes without assistance                 | <input type="checkbox"/> washes and cleans thoroughly | <input type="checkbox"/> need assistance           |
| <input type="checkbox"/> brushes teeth without assistance                                      | <input type="checkbox"/> needs assistance for teeth                | <input type="checkbox"/> has special hair needs       | <input type="checkbox"/> has special skin needs    |
| <input type="checkbox"/> must be dressed   | <input type="checkbox"/> likes to be helped                        | <input type="checkbox"/> dresses without help         | <input type="checkbox"/> likes to pick out clothes |
| <input type="checkbox"/> is allergic to certain fabrics; sensitive to scratchy materials, tags | <input type="checkbox"/> is allergic to personal grooming products |   |  |

Comments: \_\_\_\_\_

### Bathroom Routine: My child is

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> not trained                  | <input type="checkbox"/> uses diapers                            | <input type="checkbox"/> uses training pants                       | <input type="checkbox"/> partially trained, has accidents |
| <input type="checkbox"/> trained, but needs prompting | <input type="checkbox"/> daytime trained--has accidents at night | <input type="checkbox"/> trained, uses toilet, alone/few accidents |   |

Comments: \_\_\_\_\_

### Eating Habits: My child

#### Infant

- |  |   |
|--|---|
| <input type="checkbox"/> is on formula (name) _____  | <input type="checkbox"/> schedule/amount _____      |
| <input type="checkbox"/> eats baby food (name) _____ | <input type="checkbox"/> schedule/amount _____      |
| <input type="checkbox"/> is allergic to _____        | <input type="checkbox"/> needs a special diet _____ |

#### Toddler/Pre-school Child

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> is a good eater      | <input type="checkbox"/> eats three meals a day     | <input type="checkbox"/> eats balanced meals | <input type="checkbox"/> is a fussy eater | <input type="checkbox"/> likes to eat snack foods |
| <input type="checkbox"/> favorite food _____  | <input type="checkbox"/> will not touch _____       |  |   |   |
| <input type="checkbox"/> is allergic to _____ | <input type="checkbox"/> needs a special diet _____ |  |   |   |

Comments: \_\_\_\_\_

# Handout #10 LET ME TELL YOU ABOUT MY CHILD SERIES

For Children From Birth To Five Years Of Age

## Play and Relaxation: My child

### Infant

- responds to others/environment       curious/interested/playful       plays with toys       active/ energetic  
 calm/relaxed       fretful/ fussy       quiet/inactive       unresponsive to surroundings

### Toddler/Pre-School Child

- plays with other children       gets along well with others       has a special friend       has an imaginary friend  
 plays alone       does not have many friends       is very active       does not like to be active  
 likes to watch television; favorite program \_\_\_\_\_       has favorite toys, games or books: \_\_\_\_\_

Comments: \_\_\_\_\_

## Learning and Education: My child

- is in Early Education       is in Kindergarten       Name/ Address \_\_\_\_\_  
 likes to draw pictures/color       likes to read books       likes to have someone read books  
 watches children's programs  
 favorite class/activity \_\_\_\_\_       after school activities \_\_\_\_\_

Comments: \_\_\_\_\_

## Culture and Religious Tradition: My family and my child

- have special cultural traditions       have special practices       requires special diets \_\_\_\_\_  
 are members of a church/mosque/temple       attend regularly       attend occasionally       celebrate holy days/events  
 attend school for religious practices       observe religious practices  
 Name of Minister/Clergy \_\_\_\_\_       Address of church/mosque/temple \_\_\_\_\_

Comments: \_\_\_\_\_

## Responsibilities: My child

- makes bed       cleans bedroom       sets/cleans up table       gets an allowance       knows about/saves money

Comments: \_\_\_\_\_

## Special Interests: My child enjoys

- reading       play acting/pretending       dressing up       arts and crafts       cooking/baking  
 games/puzzles       computers       videogames       internet games  
 singing/choir       listening to music       dancing       musical instrument \_\_\_\_\_  
 bike riding/skating       watches sports       team sports       individual sports  
 Boys/Girls Clubs       Boy/Girl Scouts       church groups       Park programs       community activities  
 watches TV       does not show interests or have hobbies

Comments: \_\_\_\_\_

## Important People: My child is close to

- brothers \_\_\_\_\_       sisters \_\_\_\_\_  
 grandparent \_\_\_\_\_       relatives \_\_\_\_\_  
 friends \_\_\_\_\_       neighbors \_\_\_\_\_  
 teacher/coach \_\_\_\_\_       other \_\_\_\_\_

Comments: \_\_\_\_\_

# Handout #10 LET ME TELL YOU ABOUT MY CHILD SERIES

For Children From Birth To Five Years Of Age

## Health:

**Physical Health:**  my child sees a doctor or health practitioner  routine visit  special problems (explain) \_\_\_\_\_

Doctor's name \_\_\_\_\_ Address or telephone \_\_\_\_\_

last appointment was \_\_\_\_\_  next appointment \_\_\_\_\_  appointment needs to be scheduled

current medicines \_\_\_\_\_  illness \_\_\_\_\_  dosage \_\_\_\_\_  how often \_\_\_\_\_

past medicines \_\_\_\_\_  illness \_\_\_\_\_  dosage \_\_\_\_\_  how often \_\_\_\_\_

has asthma or breathing problems  needs to use an inhaler  knows how to use  knows when to use

has these allergies \_\_\_\_\_

Immunizations up to date  Immunizations are due  I have the immunization record

**Dental Health:**  My child sees a dentist Dentists Name \_\_\_\_\_ Address or Telephone \_\_\_\_\_

routine visit  no problems  special problems \_\_\_\_\_

last visit \_\_\_\_\_  next appointment \_\_\_\_\_  appointment needs to be scheduled

**Vision**  My child's vision has been tested  health professional  school name \_\_\_\_\_

last test: \_\_\_\_\_  no problems  next appointment \_\_\_\_\_  needs to be scheduled

never tested  needs appointment  has vision needs  needs/wears glasses for \_\_\_\_\_

**Hearing:**  My child's hearing was tested  health professional  school name \_\_\_\_\_

last test: \_\_\_\_\_  no problems  next appointment \_\_\_\_\_  needs to be scheduled

never tested  needs appointment  is deaf or hard of hearing  needs/uses hearing device, sign language, reads lips

(use the extra note sheet to explain health needs, medications or other instructions)

Comments: \_\_\_\_\_

## Special Issues: \_\_\_\_\_

### Strengths: My child

- is friendly  is outgoing  likes to share with others  is trustworthy  
 accepts rules easily  adapts to change easily  is persistent  has future goals

Comments: \_\_\_\_\_

### Special Challenges: My child

- is shy  is moody  is withdrawn from others  fearful around others  
 is defiant  aggressive with others  hangs with trouble peers  argues/fights with others

Comments: \_\_\_\_\_

## EXTRA NOTES ABOUT MY CHILD'S NEEDS AND CARE:

You may need more space to write down your ideas and suggestions about your child's care. Please add any additional information you think will help your child. You and your child's foster caregiver should talk about your child's needs often.

---

---

---

---

---

---

Parent's Name \_\_\_\_\_ Date Completed \_\_\_\_\_