

# Handout #11 LET ME TELL YOU ABOUT MY CHILD SERIES

## For Children From 6 to 12 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 bytelling 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"/> sleeps through the night  | <input type="checkbox"/> wakes up often during the night      | <input type="checkbox"/> has nightmares                                     |
| <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"/> with an adult family member          | <input type="checkbox"/> likes an activity before bed such as reading _____ |
| <input type="checkbox"/> sleeps with a nightlight  | <input type="checkbox"/> sometimes wets the bed               | <input type="checkbox"/> sleeps with a favorite toy or blanket _____        |

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

### Waking: My child

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> wakes up around _____        | <input type="checkbox"/> wakes up easily                    | <input type="checkbox"/> has difficulty waking up | <input type="checkbox"/> gets up after prodding |
| <input type="checkbox"/> wakes up with an alarm clock | <input type="checkbox"/> has a difficult time getting going | <input type="checkbox"/> likes to eat breakfast   | <input type="checkbox"/> skips breakfast        |

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

### Bathing, Grooming and Dressing: My child

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> washes and cleans thoroughly  | <input type="checkbox"/> baths without assistance                  | <input type="checkbox"/> need assistance                     | <input type="checkbox"/> takes care of teeth |
| <input type="checkbox"/> dresses with no help  | <input type="checkbox"/> picks out clothes                         | <input type="checkbox"/> makes good choices                  | <input type="checkbox"/> may ask for help    |
| <input type="checkbox"/> has special hair care needs   | <input type="checkbox"/> has special skin care needs               | <input type="checkbox"/> knows how to take care of hair/skin | <input type="checkbox"/> may ask for help    |
| <input type="checkbox"/> is allergic to certain fabrics; sensitive to scratchy materials, tags | <input type="checkbox"/> is allergic to personal grooming products |  |  |

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

### Eating: My child

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> is a good eater, eats three meals a day | <input type="checkbox"/> eats balanced meals | <input type="checkbox"/> likes to eat snack foods   | <input type="checkbox"/> is a fussy eater |
| <input type="checkbox"/> favorite food _____                     |  | <input type="checkbox"/> does not like _____        |   |
| <input type="checkbox"/> has an allergy to _____                 |  | <input type="checkbox"/> needs a special diet _____ |   |

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

### Education: My child

- School \_\_\_\_\_ Address \_\_\_\_\_ Grade \_\_\_\_\_  
Teacher \_\_\_\_\_ Principal \_\_\_\_\_
- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> is at grade level for age   | <input type="checkbox"/> is in a regular grade/class   | <input type="checkbox"/> is in regular class/with help    | <input type="checkbox"/> in special education class  |
| <input type="checkbox"/> likes going to school   | <input type="checkbox"/> gets good grades              | <input type="checkbox"/> does homework without assistance | <input type="checkbox"/> needs reminding to complete |
| <input type="checkbox"/> requires adult assistance   | <input type="checkbox"/> receives tutoring             | <input type="checkbox"/> refuses to do homework           | <input type="checkbox"/> at times, refuses to attend |
| <input type="checkbox"/> at times, is truant <input type="checkbox"/> has behavioral problems in school <input type="checkbox"/> worried, sad or scared about school |  |   |  |
| <input type="checkbox"/> best subject _____  | <input type="checkbox"/> hardest subject _____         |   |  |
| <input type="checkbox"/> after school activities _____   | <input type="checkbox"/> favorite class/activity _____ |   |  |

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

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

- have special cultural traditions ? special practices ? require special diets \_\_\_\_\_
- attend services  celebrate holy days/event  attend school for religious practices
- observe religious practices
- recognize special cultural traditions/events \_\_\_\_\_
- Name of Minister/Clergy \_\_\_\_\_ ? Address of church/mosque/temple \_\_\_\_\_

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

### Responsibilities: My child

- does household chores  cleans bedroom  knows how to/does laundry  can shop for groceries
- does odd jobs  saves money  baby-sits for other children  takes public transportation

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

### Play/Relaxation: My child

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

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

### Special Interests: My child enjoys

- reading  play acting/school plays  arts and crafts  cooking/baking
- games/puzzles  computers  mechanics  making videos  playing video/internet games
- singing/choir  listening to music  dancing  band  musical instrument \_\_\_\_\_
- bike riding/skating  plays team sports  watches sports  individual sports  community activities
- Boys/Girls Clubs  Boy/Girl Scouts  church groups  Park programs  does not show interests or hobbies
- makeup/hair styling  working at a job  babysitting  watching TV

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

### Important People: My child is close to

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

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

### Health

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

Doctor's name is \_\_\_\_\_ 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
- immunizations complete  has these allergies \_\_\_\_\_

**Dental Health:**  my child sees a dentist Name \_\_\_\_\_ Telephone \_\_\_\_\_

- routine visit  no problems  special problems \_\_\_\_\_
- last visit \_\_\_\_\_  next appointment \_\_\_\_\_  appointment needs to be scheduled

**Vision**  vision was tested  health professional  school name \_\_\_\_\_

- lasttest: \_\_\_\_\_  no problems  next appointment \_\_\_\_\_  needs to be scheduled
- never tested  needs appointment  has vision needs  needs/wears glasses for \_\_\_\_\_

**Hearing:**  tested for hearing  health professional  school name \_\_\_\_\_

- lasttest: \_\_\_\_\_  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

Comments \_\_\_\_\_

