



Care Information Packet



Special Learning Center

Child Information

Full Name: _____

Date of birth: _____

Preferred method of communication: _____

Address: _____

City, State, Zip: _____

Phone: _____

Alt phone: _____

Email _____

Parent Information

Mother's full name: _____

Father's full name: _____

Cell phone: _____

Work phone: _____

Home phone: _____



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Guardian Information

Guardian's full name: _____

Cell phone: _____

Home phone: _____

Work phone: _____

Email:

Physician

Physician name: _____

Hospital/Clinic name: _____

Phone number: _____



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Child Self-Help Information

Bathing:

Toileting:

Dressing:

Favorite Toys and Activities

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Seizure Information

Does the child have seizures? _____

If yes, how often? _____

What happens during the seizures?

How long do the seizures usually last?

What happens immediately before the seizure?

How should the seizure be recorded?



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Special Instructions

Any special instructions?

Describe any safety concerns:

Is there a special diet to be followed?

Favorite foods:

Disliked foods:



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Emergency Contacts

Name/Relationship/Contact
1.
2.
3.
4.

Notes/Comments/Special Instructions

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