SonShine
PRESCHOOL

Special Care Needs

Child's Name: _____ Date: _____

Date of birth: _____

Please check all that apply.

- ☐ Sensory processing issues
- ☐ Self-regulation
- ☐ Emotional/Behavioral/Social issues
- ☐ Fine/Gross Motor Coordination
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ ADD/ADHD
- ☐ Medications prescribed for continuous long-term use
  Medication: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Other: _____

Please explain any needs checked above.

_____

_____

_____

_____

_____

Have special care needs been diagnosed or addressed by a medical professional: ☐Yes ☐No

Is your child receiving any therapy? ☐Yes ☐No