Personal Fact Sheet

Name: _____

Address: _____

Home phone: _____

Name of parent(s)/guardian(s): _____

_____

Physical Conditions & Diagnoses

Condition	*Applies to Your Child*
Seizure disorder	Yes / No
Allergies	Yes / No
Diet restrictions	Yes / No
Has a shunt	Yes / No
Sensitive to the sun	Yes / No
Often chokes when eating	Yes / No
Aspirates on liquids	Yes / No
Has a G-tube	Yes / No
Has toileting issues	Yes / No
Has asthma	Yes / No

Describe the above conditions or add diagnoses below:

_____

_____

_____

_____

_____

Mobility

Method of Ambulation	*Applies to Your Child*
Walks indoors	Yes / No
Walks outdoors	Yes / No
Walks with crutches	Yes / No
Walks with walker	Yes / No
Walks with gait trainer	Yes / No
Walks with white cane	Yes / No
Uses manual wheelchair	Yes / No
Uses sighted guide	Yes / No
Has trouble traveling at night	Yes / No

Describe or add other details below:

_____

_____

Medications

Medication name *dose* *frequency*

_____

_____

_____

_____

_____

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_____

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