



## Child & Young Person All About Me

This information will assist BOSP Support Workers in giving quality care to your child/young person in your absence. Please include any relevant details you feel would give us a fuller picture, so we can ensure we meet your child's/young person's individual needs.

<b>Child/young person's name:</b>		<b>Date of birth:</b>	
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Add photo here

Sibling's names: (if applicable)	Age:

**Current diagnosis:**

<b>Behaviour exhibited:</b>							
<b>Aggressive</b>	<input type="checkbox"/>	<b>Content</b>	<input type="checkbox"/>	<b>Loud</b>	<input type="checkbox"/>	<b>Quiet</b>	<input type="checkbox"/>
<b>Isolated</b>	<input type="checkbox"/>	<b>Introverted</b>	<input type="checkbox"/>	<b>Extroverted</b>	<input type="checkbox"/>	<b>Destructive</b>	<input type="checkbox"/>
<b>Obsessive</b>	<input type="checkbox"/>	<b>Playful</b>	<input type="checkbox"/>	<b>Spitting</b>	<input type="checkbox"/>	<b>Biting</b>	<input type="checkbox"/>
<b>Punching</b>	<input type="checkbox"/>	<b>Scratching</b>	<input type="checkbox"/>	<b>Friendly</b>	<input type="checkbox"/>	<b>Other</b>	<input type="checkbox"/>

**Current management strategy:**

**Reaction to the current strategy:**

<b>Mobility:</b>							
Limited control of limbs	<input type="checkbox"/>	Bottom shuffle	<input type="checkbox"/>	Walk independently	<input type="checkbox"/>	Right sided weakness	<input type="checkbox"/>
Head control	<input type="checkbox"/>	Stand at furniture	<input type="checkbox"/>	Roll	<input type="checkbox"/>	Left sided weakness	<input type="checkbox"/>
Sit unaided	<input type="checkbox"/>	Walk unaided	<input type="checkbox"/>	Control all limbs	<input type="checkbox"/>	Stand independently	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	Walk with an aid	<input type="checkbox"/>	Pivot	<input type="checkbox"/>	Unsteady on feet	<input type="checkbox"/>

<b>Likes:</b> <b>(please list activities or specific objects)</b> <i>e.g. swimming (and specify any <u>swimming aids</u> used)</i>
<b>Communication: (speech, eye pointing, symbols, signing, gestures, vocalisations)</b> <i>e.g. PECS, Now &amp; Then Boards, Makaton, BSL etc.</i>
<b>Play, Social &amp; Learning Objectives:</b> <i>e.g. to sign please and thank you at lunch time</i>
<b>Eating &amp; Drinking:</b> <i>e.g. strict gluten free diet; will only drink from a cup provided by home</i>

<b>Dislikes:</b> <b>(please list activities or specific references)</b> <i>e.g. sudden loud noises</i>
<b>Toileting: (please include rough times if necessary)</b> <i>e.g. changing needs etc.</i>
<b>Maintaining a Safe Environment:</b> <i>e.g. 1:1 support on outings as is prone to wander; current Step-On Care Plan in place?</i>
<b>Behavioural Triggers:</b> <i>e.g. invasion of personal space</i>

<b>Cultural Needs:</b>
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<b>Any other information:</b>
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<b>Parent/Carer's Name:</b>	
<b>Signature:</b>	<b>Date:</b>