

Parent / Guardian Questionnaire

Special Needs Assistants (SNAs) are provided to schools to assist a small number children with significant care needs.

SNAs are assigned to schools to support a number of students when they most need it. Those students with the greatest level of need receive the greatest level of support. As the student becomes more independent, the level and type of support will change.

The school has identified your child as having care needs and we would like to invite you to contribute by providing more detail below.

Childs Name: _____ Class/year Group: _____

Care Needs

Feeding

Does your child have a significant difficulty with self-feeding? Yes No

If yes, please provide detail _____

If yes, how do you support your child with feeding in the home? _____

Please detail independence gained with feeding in the past 6 months _____

Toileting

Does your child have a significant difficulty with self-toileting? Yes No

If yes, please provide detail _____

If yes, how do you support your child with this difficulty in the home? _____

Please detail independence gained with toileting in the past 6 months _____

Medical

Does your child have a significant medical condition e.g. epilepsy, diabetes? Yes No

If yes, please provide details: _____

How is this likely to affect your child in school and how often? _____

Have you developed a medical response plan with the school? Yes No

Does your child require **regular** administration of medicine **during school hours**? Yes No

If yes, please give provide detail _____

Please detail independence gained with managing this condition in the past 6 months _____

Communication

Does your child have a significant difficulty with communication? Yes No

Is your child: Deaf/ Hard of Hearing Blind/Vision Impaired Pre Verbal

How does your child communicate? (please circle)

Speaking Gestures ISL/Lámh Picture Exchange iPad

What supports will your child require to assist their communication needs:

In the classroom _____

Around the school/on school outings _____

Please detail any independence gained with communication in the past 6 months _____

Behaviour of Concern

Does your child engage in any behaviours of concern? Yes No

| If Yes, circle any behaviour/s of concern. | How often does your child engage in these behaviours? | What are the common triggers? | What is your child trying to communicate? |
|---|---|-------------------------------|---|
| Disruption Shouting Screaming Flopping Eloping Running away | | | |
| Destruction Breaking Throwing Tearing Swiping | | | |
| Aggression Hitting Kicking Biting Hair pulling Spitting Pinching | | | |
| Self- Injurious Hitting own body Head banging Slamming Biting self | | | |

Please detail independence gained towards positive behaviour in the past 6 months

Mobility

Does your child have a significant difficulty with mobility? Yes No

If yes, please provide detail _____

If yes, how do you support your child with this difficulty in the home? _____

How is this likely to affect your child:

In the classroom _____

Around the school/on school outings _____

Please detail any independence gained with mobility in the past 6 months _____

Signed: _____ Date: _____

Parent / Guardian Name: _____

Phone: _____