


Name: \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Language(s) My Child Speaks: \_\_\_\_\_



- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Right-Handed | <input type="checkbox"/> Wears glasses all the time. |
| <input type="checkbox"/> Left-Handed  | <input type="checkbox"/> Wears glasses to read.      |
| <input type="checkbox"/> Not Sure Yet | <input type="checkbox"/> Doesn't wear glasses.       |


Loves to talk about: 

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Gets nervous about: 

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Reacts positively when I: 


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Reacts negatively when I: 


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Three areas where my child shines are: 

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My child lives with: 


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My goals for my child: 

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