

Welcome Back!



Dear Parents/ Guardians,

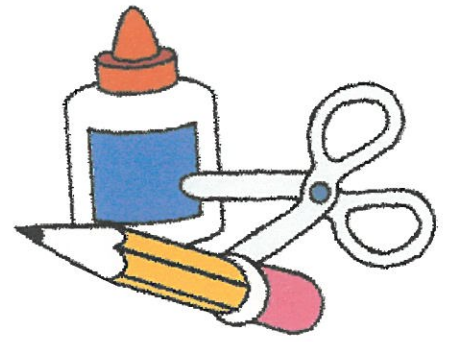
Welcome back! I hope you all enjoyed a wonderful summer and are excited for the new school year! I want to introduce myself as your child's teacher for the 2024-25 school. My name is Ms. Levin, and our classroom number is B8. This year is going to be full of fun and learning. To start, there are some things I ask of you:

- ★ Please send in school supplies, located on the next page, LABELED with your child's name on the first day of school, *Wednesday, September 4th*.
- ★ On the first day of school, please send your child in wearing the smiley face that was sent home around their neck. Please label the smiley face with your child's name, my name (Ms. Levin), and classroom number (B8).
- ★ Attached there are forms to help me learn more about your child. Please fill these out and send back to school by *Friday, September 6th*.

Thank you so much in advance! If you have any questions, please feel free to contact me at klevin@mccsd.net. I look forward to a wonderful school year!

Warm Regards,
Ms. Levin

Supply List



- (30) Glue sticks
- (1) Pencil box {can fit in desk}
- (2) 24-Count of Crayola crayons
- (2) 10-Count of Crayola markers
- (1) Pair of Fiskars kid's scissors
- (2) Boxes of pencils
- (1) Box of dry erase markers
- (2) Plastic folders
- (1) Pair of headphones (please put in Ziploc bag labeled with your child's name)
- (1) 4 pack of playdoh
- (4) Boxes of tissues
- (5) Packages of wipes
- (2) Sets of extra clothes (underwear, shirt, pants, socks) labeled with your child's name
- (1) Package of pullups, if applicable

Please send in extra food, drinks, and/or toys your child is motivated by.

Wish List 😊

- Small Ziploc baggies
- Large Ziploc baggies
- Plastic Cutlery
- Paper Plates

Student Preference Assessment

Student Name: _____

DOB: _____ Date Completed: _____

CHECK ALL THAT APPLY:

Sensory Reinforcers

- ☐ Swinging
- ☐ Blowing Bubbles
- ☐ Being Held
- ☐ Squeezes
- ☐ Jumping
- ☐ Roll up in a blanket
- ☐ Jumping
- ☐ Spinning
- ☐ Back rub
- ☐ Olfactory (smell)
- ☐ Pressure
- ☐ Other: _____

Social Reinforcers

- ☐ Hugs
- ☐ Adult attention
- ☐ High Five
- ☐ Verbal Praise
- ☐ Thumbs up
- ☐ Applause
- ☐ Eye contact
- ☐ Hand Shake
- ☐ 1 on 1 time
- ☐ Sit with adult
- ☐ Tickles
- ☐ Other: _____

Activity Reinforcers

- ☐ Drawing
- ☐ Paint
- ☐ Books
- ☐ Computer
- ☐ Ipad
- ☐ Puzzles
- ☐ Water play
- ☐ Sand play
- ☐ Musical toys
- ☐ Going for a walk
- ☐ Dress up
- ☐ Other: _____

Interests

- ☐ Animals
- ☐ Alphabet
- ☐ Cars
- ☐ Dolls
- ☐ Dinosaurs
- ☐ Numbers
- ☐ Shapes
- ☐ Tools
- ☐ Trains
- ☐ Trucks
- ☐ Weather
- ☐ Other: _____

FAVORITE:

Drinks: _____

Foods: _____

TV Shows: _____

Movies: _____

Characters: _____

Other: _____

Student Preference Assessment

Activities (list favorite):

Music (list songs/artists):

Toys (list preferred toys):

ITEMS THE STUDENT DOES NOT LIKE

Drinks: _____

Food: _____

TV
Shows: _____

Movies: _____

Other: _____

Getting to Know Your Child

Name: _____ Nickname (if one): _____

Allergies: _____

Medical Concerns: _____

1. Will your child: (circle) **buy** **bring** lunch?

2. Are they able to choose their own lunch? **Yes** **No**

If "no," please communicate in written form what your child will be buying each day.

3. Is your child verbal? **Yes** **No**

4. If your child is NOT verbal, how do they get their wants/needs met?

5. Is your child toilet trained? **Yes** **No**

6. If your child is NOT toilet trained, does he/she tell you when they need to use the bathroom? **Yes** **No**

7. If your child IS toilet trained but does not tell you when he/she needs to use the bathroom, how often do you take him/her to the bathroom?

8. Would it be appropriate to use edibles as a reinforcers for your child in the classroom? **Yes** **No**

9. Please list a few items (toys/edibles) that your child enjoys so that I can use these items as reinforcers in the classroom:

10. Does your child have a difficult time with transitions? **Yes** **No**

11. Will your child attend the after school program? (Start date to be announced) (Monday-Thursday, 3:10-4:10)

a. **Yes** **No**

12. Does your child display aggression toward him/herself or others? **Yes** **No**

If yes, please explain: _____

13. Please indicate any strategies that you have used with your child that you feel would be useful for his/her teachers:

14. Please indicate your biggest concern at this time regarding your child and his/her needs:

15. Does your child have any sensory needs?

Parent Communication

Child's Name: _____

Parent's Name(s): _____

Parent Emails: _____

Home Phone: _____

Cell Phone 1: _____

Cell Phone 2: _____

How do you prefer to be contacted?

Phone

Email

Note Home