JUNIOR KINDERGARTEN HALF DAY CLASSROOM INFORMATION SHEET – 2016-2017
STAFF – GABY LUTRIN & SIGAL MATHEWS

CHILD'S FULL NAME: ______________________________

BIRTH DATE: ______________________________

ALLERGIES: ______________________________

REACTION: ______________________________

ANY DAILY MEDICATIONS: ______________________________

PARENT 1 FULL NAME: ______________________________

ADDRESS: ______________________________

HOME PHONE: ______________________________

WORK PHONE: __________ **DAYS:** __________ **HOURS:** __________

CELL PHONE: ______________ **OCCUPATION:** __________

E-MAIL: ______________________________

PARENT 2 FULL NAME: ______________________________

ADDRESS: ______________________________

HOME PHONE: ______________________________

WORK PHONE: __________ **DAYS:** __________ **HOURS:** __________

CELL PHONE: ______________ **OCCUPATION:** __________

E-MAIL: ______________________________

EMERGENCY CONTACT PERSONS (if parents are unavailable):

1 ______________ **PHONE:** ______________

2 ______________ **PHONE:** ______________

Other family members: ______________________________

____

Pets: ______________________________________

Hobbies (i.e. music, art, etc. that you would be willing to share with us):

____

Does your child nap? ____________________

Does your child dress him/herself? ____________________

Any special dietary restrictions? Please specify.

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____

Any eating problems? Please specify.

____

Child's favourite activities: ____

____

Has your child attended other programs? Please specify.

____

____

Does your child have any fears? Please specify.

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Is there anything else you would like to share with us about your child that would help us address his/her particular needs?

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This questionnaire is to allow us a better understanding of your child and all information will be kept *confidential*.

Please return to YOUR CHILD'S TEACHER by the

FIRST DAY of school.

PLEASE PRINT CLEARLY