# Early Learning Center

## Parent Questionnaire

Child's Name ________________________________________________ Date of Birth: _________________
First Middle Last

Place of Birth (City) ______________________ Race: _________________ Language _________________

Parent's Name _________________________________/_________________________________________
mother father

Address ___________________________________________________ Phone #: _____________________

Mother's cell phone # _________________________ e-mail ______________________________________

Father's cell phone # _________________________ e-mail _______________________________________

## Program Request

Is your child a sibling of a current or recent ELC student? Yes__ No__ Name_______________________

Please circle and indicate 1st and 2nd choice if you have one

Circle one: _______AM (5 day) _______PM (4 day)

Do you have a request for a specific teacher? __________________________________

**All requests are based on availability and the needs of the program**

## Personal Information

1. Number of siblings____ Name and ages_____________________________________________________

_________________________________________________________________________________________

2. School Experience _____________________________________________________________________

3. List your child's favorite activities: _________________________________________________________

_________________________________________________________________________________________

## Medical Information

____Wears Glasses ____ Ear Infections ____Tubes in Ears

__ Yes ___No Allergies ____ Seizures ____ Medications

Other Health Information __________________________________________________________________

_________________________________________________________________________________________