



PRESCHOOL 4 (1) CLASSROOM INFORMATION SHEET – 2015-2016

PRESCHOOL 4 (1) 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.

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.

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

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