HOME/HEALTH INFORMATION

NAME OF CHILD_____NICKNAME (if any)_____BIRTHDATE_____

STREET ADDRESS_____P. O. BOX #_____

CITY, STATE, ZIP_____

HOME TELEPHONE #_____HOME EMAIL_____

DAD'S NAME_____DAD'S CELL #_____

DAD'S OCCUPATION AND EMPLOYER_____

DAD'S WORK EMAIL_____DAD'S WORK #_____

MOM'S NAME_____MOM'S CELL #_____

MOM'S OCCUPATION AND EMPLOYER_____

MOM'S WORK EMAIL_____MOM'S WORK #_____

DOES YOUR CHILD HAVE ANY:

- Allergies?_____
- Difficulties with speech, vision, or hearing?_____
- History of hospitalization or surgery?_____
- Daily medication?_____
- Special interests?_____
- Fears?_____
- Responsibilities at home?_____

DOES YOUR CHILD LIVE WITH BOTH PARENTS?_____IF NOT, WHO?_____

PLEASE LIST THE NAMES AND AGES OF YOUR CHILD'S SIBLINGS_____

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PLEASE LIST THE NAME OF YOUR CHILD'S PRESCHOOL AND YEARS ATTENDED_____

WHAT FORM OF DISCIPLINE DO YOU USE AT HOME?_____

PLEASE SHARE ANY ADDITIONAL INFORMATION THAT WOULD HELP US UNDERSTAND YOUR CHILD BETTER_____

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