



# Grace Children's Learning Center

A Ministry of Grace United Methodist Church

9750 Wellington Rd Manassas, VA 20110

703-393-2345 phone 703-330-0663 fax

www.graceangels.org

## Student Information

First	Middle	Last Name	Name to use in class	Sex
Date of Birth	Child's Social Security #	Street Address	City	State & Zip

Allergies and all Known Medical Conditions and How They Manifest Themselves: \_\_\_\_\_

## Parent Information



Mother's Full Name	Mother's Home Phone #
Mother's Street Address (If different from Students)	City State & Zip
Mother's Cell Phone	Mother's E-mail
Mother's Employer	Work Phone #

Father's Full Name	Father's Home Phone # (If different f)
Father's Street Address (If different from Students)	City State & Zip
Father's Cell Phone	Father's E-mail
Father's Employer	Work Phone #

## Emergency Contact Information

Persons to be contacted in case of illness, accident or emergency and authorized to pick-up my child from school if parents are unreachable. (Minimum of 2 required)

1st Contact's Name	Home Phone	Cell Phone	Work Phone
1st Contact's Street Address	City	State & Zip	
2nd Contact's Name	Home Phone	Cell Phone	Work Phone
2nd Contact's Street Address	City	State & Zip	

## Personal Information

Additional Persons who have permission to pick my child up from school. \_\_\_\_\_

Have you or any professionals expressed concerns regarding your child's physical, cognitive or social development? If so, please explain. Please specify if your child is currently or has previously received early intervention or services. We will need a copy of any IEP that your child may have to better meet his/her individual needs.

Please describe previous school or group experiences your child has had. \_\_\_\_\_

Does your child typically separate from you easily? \_\_\_\_\_ yes \_\_\_\_\_ no Please provide any additional thoughts you may have to help lessen separation anxiety.

Please list siblings and other family members who live in the home and or immediate area.

Name	Relationship	Reside in Home
_____	_____	Yes or No
_____	_____	Yes or No
_____	_____	Yes or No
_____	_____	Yes or No
_____	_____	Yes or No
_____	_____	Yes or No

Please help us understand how your child socializes with peers and adults. Are they outgoing or shy? Are they comfortable with hugs when upset?

How does your child typically respond when frustrated with peers? Adults? An activity or task? \_\_\_\_\_

What language(s) are spoken in the home? \_\_\_\_\_



## Medical Information

\_\_\_\_\_  
Child's Physician's Name

\_\_\_\_\_  
Physician's Phone Number

\_\_\_\_\_  
Physician's Complete Address

\_\_\_\_\_  
Child's Dentist's Name

\_\_\_\_\_  
Dentist's Phone Number

\_\_\_\_\_  
Dentist's Complete Address

### Does your child have frequent:

Colds?\_\_\_\_\_ Coughs?\_\_\_\_\_ Tonsillitis?\_\_\_\_\_ Ear infections?\_\_\_\_\_ Nausea?\_\_\_\_\_ High fever?\_\_\_\_\_

Convulsions?\_\_\_\_\_ Stress with Anxiety? \_\_\_\_\_ Conjunctivitis? \_\_\_\_\_ Impetigo?\_\_\_\_\_ Lice? \_\_\_\_\_

Acid Reflux? \_\_\_\_\_ Headaches? \_\_\_\_\_ Trouble Sleeping?\_\_\_\_\_

**Describe any Learning Disabilities, Diagnosis, Serious Illness, Communicable Diseases, Dietary Restrictions, Medical Conditions, Surgeries, Life Changing Events or Other Information that will help us best meet your child's needs.**

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What do you consider your child's strength and weakness to be?

What are your hopes and dreams for your child this year?

