



# 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

\_\_\_\_\_  
Child's Home Phone Number

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

\_\_\_\_\_

\_\_\_\_\_

## Parent Information



\_\_\_\_\_  
Mother's Full Name Mother's Home Phone # (If different from Student's)

\_\_\_\_\_  
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 from Student's)

\_\_\_\_\_  
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 has to better meet his/her individual needs. 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.

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

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

<b>Name</b>	<b>Relationship</b>	<b>Reside in Home</b>
_____	_____	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?

What languages are spoken in the home? \_\_\_\_\_

## Medical Information

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

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

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

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

## **“Get to Know Me”**

Previous experience in a preschool setting. Include structured and unstructured.

How does the child respond in small group settings and large group settings?

Please tell us about how your child interacts with familiar adults and with strangers:

Please tell us about your child’s attention span with structured activities:

Speech/Language. What is your child’s vocabulary like. Are there any speech concerns? Do strangers understand your child? Etc.

Please tell us about any major life changes your child has experienced in the past 6 mths and or expecting within the next year.

How does your child deal with challenging situations with things, with peers and with adults.

How does your child typically respond to redirection and authority figures?

Please tell us a bit about your child’s personality. Do you anticipate any difficulty with separation anxiety?

What are your child’s favorite activities? Is there anything your child does not enjoy or is fearful of?

Other concerns, or comments: