



Towns County Kindergarten (5 yrs. Old) Information Sheet

Date _____

Full Name of Child: _____
First Middle Last

Date of Birth _____ Place of Birth _____

SS# _____ City County St.

Name Called By: _____ Native Language _____ Sex: _____

Age _____ Ethnicity _____ Home Phone _____

Child's Address _____ City _____ State _____

Did Your Child Attend Pre-K _____ Headstart _____ Where _____

Father's Full Name _____

Name & Address of Employer _____

Occupation _____ Daytime Phone _____

Home Address (If different from Child's) _____

Mother's Full Name _____

First Middle Last

Name & Address of Employer _____

Occupation _____ Daytime Phone _____

Home Address (If different from Child's) _____

Marital Status of Parents: Single ___ Married ___ Divorced ___ Separated ___

Name(s) of Step-Parents if Any _____

Child Lives with (Give Relationship) _____

Number of People Living in Household _____ Child's Legal Guardian (s) _____

Names of All Brothers & Sisters Living in Home:

Name	Age	Grade
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Please List People Who are Allowed to Pick-up Your Child Phone #

IF CHILD IS ILL OR INJURED AT SCHOOL AND PARENT(S) CANNOT BE REACHED,
WHO SHOULD BE CONTACTED?

1. _____
NAME PHONE RELATIONSHIP TO CHILD
2. _____
3. _____

HOW WILL YOUR CHILD GET TO AND FROM
SCHOOL? _____

BUS NUMBER _____ BUS DRIVERS NAME _____

DIRECTIONS TO HOME

IN CASE OF AN EMERGENCY (EARLY) SCHOOL CLOSING, PLEASE GIVE THE
FOLLOWING INFORMATION IF KNOWN.

BUS # _____ BUS DRIVER'S NAME _____ DESTINATION _____

OTHER INSTRUCTIONS _____

HEALTH INFORMATION

HAS YOUR CHILD HAD ANY OF THE FOLLOWING?

ASTHMA _____ SPEECH PROBLEMS _____

EPILEPSY _____ HEARING PROBLEMS _____

DIABETES _____ VISION PROBLEMS _____

ALLERGIES PHYSICAL HANDICAP _____

FOOD _____

BEE STING _____

MEDICATION _____

SERIOUS ILLNESSES OR ACCIDENTS?

OTHERS (SPECIFY
PLEASE EXPLAIN ANY OF THE ABOVE. _____

HAS YOUR CHILD EVER HAD ANY EXPERIENCE THAT MIGHT HAVE UPSET HIM/HER
EMOTIONALLY? EXPLAIN: _____