

**Early Childhood Program
Parent/Guardian Questionnaire
2014-15 School Year
Prekindergarten (3K)**

*Please complete all information **except** in gray spaces labeled: **FOR SCHOOL USE ONLY***

SCHOOL:		
CHILD		
Last name:	First name:	Middle name:
Check if Applicable: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> Jr. <input type="checkbox"/> Sr.		
Date of Birth (mm/dd/yy): __/__/__ Social Security number (Preferred but optional): ____-____-____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
PARENTS/GUARDIANS		
Mother's last name:	First name:	Middle initial:
Father's last name:	First name:	Middle initial:
LOW BIRTH WEIGHT		
Did your child weigh less than 5.5 lbs. at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No		
INCOME RANGE		
Income Range of Family:		
<input type="checkbox"/> \$0-\$10,000 <input type="checkbox"/> \$10,001-\$20,000 <input type="checkbox"/> \$20,001-\$30,000 <input type="checkbox"/> \$30,001-\$40,000 <input type="checkbox"/> \$40,001-\$50,000 <input type="checkbox"/> \$50,001-\$60,000 <input type="checkbox"/> \$60,001 and above		
PRIOR CHILDCARE		
<input type="checkbox"/> Last year my child attended a child care center. (Name of center: _____) <input type="checkbox"/> Last year my child attended a Home Daycare facility. (Name of facility: _____) <input type="checkbox"/> Last year my child attended a Head Start center. (Name of center: _____) <input type="checkbox"/> Last year my child was at home with a family member. <input type="checkbox"/> Last year my child was at home with a non-family member (not a licensed Home Daycare facility). <input type="checkbox"/> None of the above.		
MEDICAL CARE SOURCE		
My child receives regular medical care from: <input type="checkbox"/> C =Free Health Clinic (Free Health Dept.) <input type="checkbox"/> E =Emergency Room		
<input type="checkbox"/> F =Family Doctor <input type="checkbox"/> O =Other		
EARLY CHILDHOOD PLACEMENT (current school year)		FOR SCHOOL USE ONLY
<input type="checkbox"/> 4 yr Class <input type="checkbox"/> Multi-Age Classroom		
CLASS TYPE <input type="checkbox"/> DSF-District Owned School Based Full-day <input type="checkbox"/> DSH District Owned School Based Half-day <input type="checkbox"/> OF-Other Full-day		FOR SCHOOL USE ONLY
FIRST STEPS Blank = Classroom is receiving no funding by First Steps		FOR SCHOOL USE ONLY
FAMILY LITERACY SERVICE		
Who in your family has participated in a school district Family Literacy Program such as adult literacy, adult education (GED, High School Diploma, ESL), parent education, child development, or parent and adult/child interactive literacy?		
<input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> No one		
If someone in your family received these services, check the box that indicates how many years.		
<input type="checkbox"/> Under 1 Year <input type="checkbox"/> 1-2 Years <input type="checkbox"/> 2-3 Years <input type="checkbox"/> 3-4 Years		

CHILD'S SPECIAL NEEDSStudent's Disability Status: None Emotional Learning Physical Speech Other _____**HEAD START**Did your child attend a Head Start center? Yes No**CLASS CURRICULUM****FOR SCHOOL USE ONLY**

What type of curriculum is currently used in the classroom?

 01-High/Scope 02-Montessori 03- Project Approach/Reggio 04-Creative Curriculum 05=Other**EDUCATION LEVEL MOTHER/FEMALE GUARDIAN**Mother/Female Guardian's Education (*highest level*) No H.S. Diploma GED H.S. Diploma Associate Bachelor Master Ph. D

Mother/Female Guardian's number of years attended school:

- 1 year 2 years 3 years 4 years 5 years 6 years 7 years 8 years 9 years
- 10 years 11 years 12 years 13 years 14 years 15 years 16 years 17 years
- 18 years 19 years 20 years 21 years 22 years 23 years 24 years 25 years
- 26 years 27 years 28 years 29 years 30 years

Name of person completing form _____ Relationship to child _____

Below is for School Use Only**Medicaid:** Yes No **Medicaid number:** _____ **Medicaid Active** Yes No**Migrant:** Yes No**State Id #:** _____