Early Childhood Program
Parent/Guardian Questionnaire
2014-15 School Year
Prekindergarten (4K)

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

SCHOOL:

CHILD

Last name: First name: Middle name:
Check if Applicable: ☐II ☐III ☐IV ☐V ☐ Jr. ☐ Sr.

Date of Birth *(mm/dd/yy)*:__/_ _/__ Social Security number *(Preferred but optional)*: _____-___-_____ Sex: ☐ M ☐ 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? ☐Yes ☐ No

INCOME RANGE

Income Range of Family:
☐ $0-$10,000 ☐ $10,001-$20,000 ☐ $20,001-$30,000 ☐ $30,001-$40,000

☐ $40,001-$50,000 ☐ $50,001-$60,000 ☐ $60,001 and above

PRIOR CHILDCARE

☐ Last year my child attended a child care center. (*Name of center:* _____)
☐ Last year my child attended a Home Daycare facility. (*Name of facility:* _____)
☐ Last year my child attended a Head Start center. (*Name of center:* _____)
☐ Last year my child was at home with a family member.
☐ Last year my child was at home with a non-family member (*not a licensed Home Daycare facility*).
☐ None of the above.

MEDICAL CARE SOURCE

My child receives regular medical care from: ☐ **C**=Free Health Clinic (Free Health Dept.) ☐ **E**=Emergency Room

☐ **F**=Family Doctor ☐ **O**=Other

EARLY CHILDHOOD PLACEMENT (current school year) **FOR SCHOOL USE ONLY**

☐ 4 yr Class ☐ Multi-Age Classroom

CLASS TYPE ☐ DSF-District Owned School Based Full-day ☐ DSH District Owned School Based Half-day
☐ 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?

☐ Both Parents ☐ Mother ☐ Father ☐ Guardian ☐ No one

If someone in your family received these services, check the box that indicates how many years.

☐ Under 1 Year ☐ 1-2 Years ☐ 2-3 Years ☐ 3-4 Years

CHILD'S SPECIAL NEEDS

Student's Disability Status: ☐ None ☐ **E**motional ☐ **L**earning ☐ **P**hysical ☐ **S**peech ☐ **O**ther_____

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 #: _____

This form has 2 sides. Please complete the front and the back.