



Hamden Early Learning Program

**Applicant Information**

Childs Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  Male or Female

Neighborhood School:  Ridge Hill  Spring Glen  West Woods  Shepard Glen  
 Helen St.  Church St.  Bear Path  Dunbar Hill

**Parent/Guardian Information**

Full Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Home number: \_\_\_\_\_ Cell number: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Email: \_\_\_\_\_

**Parent/Guardian Information**

Full Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Home number: \_\_\_\_\_ Cell number: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Email: \_\_\_\_\_

**Preschool Experience**

Is your child enrolled in a Childcare or Preschool? Yes  No  If Yes, Name of the Program: \_\_\_\_\_

How many hours per week did your child attend the Program  0-15 Hours per week  15-30 Hours per week

More than 30 hours per week

**Family Information**

Is English your first Language? \_\_\_\_\_

What Languages are spoken in your home? \_\_\_\_\_

Please check all that apply:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Bi Racial
- Hispanic / Latino
- Other \_\_\_\_\_

**Other Family Members living at home**

- 1. \_\_\_\_\_ Date of Birth: \_\_\_\_\_
- 2. \_\_\_\_\_ Date of Birth: \_\_\_\_\_
- 3. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Authorization for Pickup**

List three people that we may contact during the school day and to whom your child may be released to if you cannot be reached.

- Name: \_\_\_\_\_ Number: \_\_\_\_\_
- Relationship to child: \_\_\_\_\_ Email: \_\_\_\_\_
- Name: \_\_\_\_\_ Number: \_\_\_\_\_
- Relationship to child: \_\_\_\_\_ Email: \_\_\_\_\_
- Name: \_\_\_\_\_ Number: \_\_\_\_\_
- Relationship to child: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Care**

Are there any medical concerns or allergies that we should know about?  Yes  No

If Yes, please provide Details: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Physician Address: \_\_\_\_\_ Physician Number: \_\_\_\_\_

In case of an Emergency may we take your child to the Hospital? Yes  No  Hospital of choice: \_\_\_\_\_

Dental Care Provider/Dentist: \_\_\_\_\_ Provider Number: \_\_\_\_\_

**Parent Signature**

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/ Guardian Print name: \_\_\_\_\_ Childs Name: \_\_\_\_\_

