PROGRAM ATTENDANCE FORM

Child's Name: ____

Child's Teacher: ____________________________________ School Year: ____________________

PART ONE: Please list all licensed daycare institutions or home daycares your child has attended. If none, write NONE. If more room is needed, please attach a separate sheet of paper.

1. Provider Name: ____

   City/State: _____________________________ Dates of Attendance: ___________________

2. Provider Name: ____

   City/State: _____________________________ Dates of Attendance: ___________________

PART TWO: Please list all organized programs in which your child currently participates (i.e. other preschool programs, sports teams, dance classes, etc.). If none, write NONE. If more room is needed, please attach a separate sheet of paper.

1. Provider Name: ____

   City/State: _____________________________ Dates of Attendance: ___________________

2. Provider Name: ____

   City/State: _____________________________ Dates of Attendance: ___________________

3. Provider Name: ____

   City/State: _____________________________ Dates of Attendance: ___________________

4. Provider Name: ____

   City/State: _____________________________ Dates of Attendance: ___________________

5. Provider Name: ____

   City/State: _____________________________ Dates of Attendance: ___________________

Date of First Enrollment at Annandale Cooperative Preschool ____

Date of Termination of Enrollment at Annandale Cooperative Preschool ____________________________________

TURN FORM OVER AND COMPLETE BACK SIDE

EDUCATIONAL SERVICES FORM

Child's Name: ____

Child's Teacher: ____________________________________ School Year: _____________________

Please list <u>any other educational services your child is currently receiving</u> such as speech therapy, physical therapy, Child Find, another preschool, etc. If none, write NONE. If more room is needed, please attach a separate sheet of paper.

1. Name of Preschool or Organization: ____

   Teacher/therapist name: ____

   Phone number: ____

   Day(s) and time attending: ____

2. Name of Preschool or Organization: ____

   Teacher/therapist name: ____

   Phone number: ____

   Day(s) and time attending: ____

3. Name of Preschool or Organization: ____

   Teacher/therapist name: ____

   Phone number: ____

   Day(s) and time attending: ____

To better serve your child, the teacher may contact the teacher(s) and/or therapists(s) listed above.

I, ____ give the teaching staff at ACPS permission to contact the teachers and/or therapists listed above.

Parent/Guardian Signature: ____________________________________ Date: ______________________