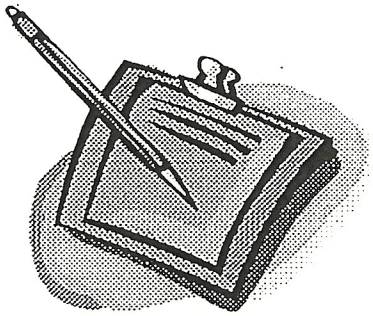
Wednesday

FIRST DAY SHEET



HOUR _____

NAME

_____

ADDRESS

_____

HOME PHONE: _____

PARENT CELL PHONE: _____

WITH WHOM DO YOU LIVE? (CIRCLE ONE)

MOTHER AND FATHER	MOTHER ONLY
FATHER ONLY	MOTHER AND STEPFATHER
FATHER AND STEPMOTHER	GRANDPARENT(S)
GUARDIANS	OTHER (SPECIFY) _____

PLEASE GIVE THE FIRST AND LAST NAMES OF THE PERSONS CIRCLED ABOVE

_____

_____

Conditions of Health (circle each factor below that applies)

Glasses	**Yes**	**No**	**Speech Problem**	**Yes**	**No**
Hearing Problem	**Yes**	**No**	**Cardiac Concerns**	**Yes**	**No**
Diabetes	**Yes**	**No**	**Allergies**	**Yes**	**No**
Asthma	**Yes**	**No**			
Epilepsy	**Yes**	**No**			
			On Medication(s)	**Yes**	**No**
ADD/ADHD	**Yes**	**No**	**If yes, explain** _____		

WHAT IS YOUR FAVORITE

CLASS_____

BOOK_____

MAGAZINE_____

MOVIE_____

T.V.SHOW_____

MUSIC_____

FOOD_____

SPORT/HOBBY_____

SATURDAY ACTIVITY_____

Do you have a computer at home?	A printer?	Access to the internet?
Yes No	Yes No	Yes No