Student First Day Form (Staff Use Only) Class: _____ Teacher: _____

Child's Name: _____ DOB: _____

Parent Name #1: _____ Phone #: _____

Parent Name #2: _____ Phone #: _____

Allergies: Yes ☐ No ☐ If yes, list allergies: _____

How to treat allergy: _____

Is allergy listed in the classroom/kitchen? Yes ☐ No ☐ If no, notify director immediately!

Medications: Yes ☐ No ☐ If yes, list medications & how to administer: _____

_____

Dietary Needs (if any): _____

Calm Down Techniques: _____

_____

Behavioral needs (if any): _____

_____

Have you taken a picture of the child for their file & birthday wall? Yes ☐ No ☐

Please provide notes, feedback & observations on student's first day: _____

_____

_____