



Little
Learner's
Exploration
Academy

APPLICATION FOR ENROLLMENT 2026/27

APPLICATION DATE: _____ SCHOOL START DATE: _____

CHILD'S NAME _____

FIRST NAME: _____ M.I. _____

LAST NAME _____ SEX _____

CHILD'S BIRTHDATE: _____

FULL ADDRESS: _____

CITY: _____ ZIP CODE: _____

HOME PHONE #: _____ CELL PHONE: _____

NATIVE LANGUAGE: _____

PARENT/GUARDIAN INFORMATION

FATHERS/GUARDIAN/ NAME: _____ OCCUPATION: _____

HOME ADDRESS: _____

WORK ADDRESS: _____ HOME PHONE #: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: _____ LANGUAGE SPOKEN AT HOME: _____

MOTHERS/GUARDIAN/ NAME: _____ OCCUPATION: _____

HOME ADDRESS _____

WORK ADDRESS _____

PHONE # _____ CELL

PHONE _____ EMAIL

_____ MARITAL STATUS _____

SIBLINGS LIVING AT HOME: YES NO

SIBLING NAME _____ AGE _____

OTHER MEMBERS LIVING IN THE HOUSEHOLD

EMERGENCY CONTACT PERSONS (2 INDIVIDUALS MUST BE LISTED)

NAME: _____

RELATIONSHIP: _____

CELL PHONE NUMBER: _____

NAME _____

RELATIONSHIP: _____

CELL PHONE NUMBER: _____

AUTHORIZED PICK-UP PERSONS

For the safety of your child, these are the ONLY people besides your emergency contacts that the preschool will release your child to. They will be asked to show photo identification

NAME: _____ RELATIONSHIP: _____

HEALTH INFORMATION

CHILD'S HEALTH RECORD: (A copy of your child's immunizations and current physical will be needed)

GENERAL STATE OF HEALTH: _____

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? _____

(Please attach a copy of immunizations. This should include the signature of nurse or doctor who administered medications.)

MEDICAL INSURER _____

MEDICAL PLAN AND NUMBER _____

DOCTOR'S NAME: _____ ADDRESS: _____
PHONE # _____

DENTIST NAME _____ ADDRESS: _____
PHONE # _____

DENTIST MEDICAL PLAN AND NUMBER: _____

ALLERGIES: YES NO DETAILS: _____

Are you concerned that your child may be prone to any type of allergies? _____

Describe: _____

Does your child have any medical conditions which we should be made aware of?

Describe: _____

Does your child have any problems with any of these? Has your child had any of these diseases?

Mark all that apply

<input type="checkbox"/> Constipation	<input type="checkbox"/> Asthma
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Frequent Sore Throats	<input type="checkbox"/> Impetigo

<input type="checkbox"/> Lice	<input type="checkbox"/> Measles
<input type="checkbox"/> Ringworm	<input type="checkbox"/> Mumps
<input type="checkbox"/> Skin Rash	<input type="checkbox"/> German Measles
<input type="checkbox"/> Soiling	<input type="checkbox"/> Polio
<input type="checkbox"/> Stomach Upsets	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Urinary Problem	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Worms	<input type="checkbox"/> Whooping Cough

Does your child have any speech, hearing or visual problems? _____

Please Explain:

Are there any restrictions for play or activities?

Please Explain:

ABOUT YOUR CHILD

Has your child ever been in child care before? _____ What type?

Was it a positive experience? _____

Why are you looking for child care? _____

How does your child feel about daycare and being left by his/her mommy/daddy?

Are there any recent traumatic situations the child has been exposed to such as a death in the family, divorce, new sibling etc.?

What is your normal method of discipline?

What is your child's temperament? Are they easy going, hard to please, nervous, aggressive, etc.

Please Explain: _____

Are there any food restrictions? _____

Please Explain:

What are your child's favorite foods? _____

What foods does your child dislike? _____

Can your child be relied upon to indicate bathroom wishes? _____

What words does your child use for: Bowel Movements _____

Urination: _____

What time does your child usually wake up? _____

What time does your child commonly go to sleep at night? _____

Do they sleep through the night? _____

Does your child sleep in a bed or crib, other? _____

Has your child had experience playing with other children?

What language(s) are spoken at home? _____

Does your child have any security objects such as a blanket, soother, bottle, toy, etc.?

What are your child's favorite activities, toys, books, or games?

Are there any other comments or information you would like to let us know about?

Any specific concerns?
