



PARENT ENROLLMENT QUESTIONNAIRE / SUMMARY

Parent Name: \_\_\_\_\_ Email address: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternative #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Are you (circle one):      Single              Married              Divorced Separated              Widowed

Please complete the following for children receiving services :

Name: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

Is the MOTHER of the child(ren) living with the family?      Yes              No

Is the FATHER of the child(ren) living with the family?      Yes              No

Please indicate if YOU are currently (circle all that apply):

Working              Seeking for work/training              Training              Incapacitated

Location: \_\_\_\_\_

Schedule:

Monday      Tuesday      Wednesday      Thursday      Friday      Satu rday      Sunday

Hours: \_\_\_\_\_/wk

Tell us about your family situation, living situation, children's development, any vocation/professional goal, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have Medical? \_\_\_\_\_ Do you have Dental? \_\_\_\_\_ Do you have reliable transportation? \_\_\_\_\_

Do you need any other resources? \_\_\_\_\_

Do you have any other comments/needs? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_