**Enrollment Form**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student Details | | | | | | | | | | | |
| Child’s Full Name |  | | [Preferred Name](https://www.google.com/search?rlz=1C1GGGE_enUS467US475&espv=2&biw=1920&bih=955&q=preferred+name&spell=1&sa=X&ved=0ahUKEwjR9svomO3NAhVN-2MKHa5XCtwQvwUIGSgA) | | |  | | | | | |
| Birth Date |  | | Age | | |  | | | Gender | |  |
| Father/Guardian Details | | | | | | | | | | | |
| Full Name |  | | | Email Address | |  | | | | | |
| Home Phone |  | Cell Number |  | | | | Work Number | | |  | |
| Home Address |  | | | | | | | | | | |
| Employer’s Address |  | | | | | | | | | | |
| Mother/Guardian Details | | | | | | | | | | | |
| Full Name |  | | | Email  Address |  | | | | | | |
| Home Phone  (if different from above) |  | Cell Number |  | | | | | Work Number | |  | |
| Home Address  (if different from above) |  | | | | | | | | | | |
| Employer’s Address |  | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| EMERGENCY CONTACTS (OTHER THAN PARENT) AUTHORIZED TO PICK UP YOUR CHILD | | | | |
| Contact1 | | | | |
| Full Name |  | | Relationship |  |
| Address |  | | | |
| Home Phone |  | | Cell Phone |  |
| Contact2 | | | | |
| Full Name: |  | | Relationship |  |
| Address |  | | | |
| Home Phone |  | Cell Phone | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| MEDICAL INFORMATION | | | |
| Physician’s Name |  | Phone |  |
| Address |  | Preferred Hospital |  |
| Date of last exam |  | Date of last Tetanus or DTAP Immunization |  |
| Medical Insurance |  | Insurance Number |  |
| Allergies: (In case of allergies, please fill additional form signed by allergy doctor) |  | | |
| Dietary Preferences |  | | |



Parent or guardian signature Date



Parent or guardian signature Date

**Consent for Emergency Treatment**

I hereby give permission for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to

• Be given emergency treatment by a qualified staff member at Stellar Montessori Academy.

• Be transported by ambulance or aid car to an emergency center for treatment.

• Receive medical, surgical and hospital care, treatment and procedures by all licensed physicians or hospital when deemed immediately necessary or advisable by the physician to safeguard my child’s health.



Parent or guardian signature Date



Parent or guardian signature Date

**Photo Permission Form**

I give Stellar Montessori Academy permission to take pictures at the school/class during work time and use for website/flyers/Facebook/newsletters of my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No 

I give Stellar Montessori Academy permission to take pictures pictures only for school related projects of my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No 



Parent or guardian signature Date



Parent or guardian signature Date