

EARLY CHILDHOOD PROGRAMME APPLICATION FORM

Section 1

Student's Legal Name:

FIRST MIDDLE LAST

Date of Birth: ____ / ____ / ____

DAY MONTH YEAR

Home Address:

Street City

Gender: Male Female

Section 2

Mother's Name:

FIRST MIDDLE LAST

Mother's Home Phone: _____

Mother's Mobile Phone: _____

Place of Employment: _____

Occupation: _____

Business Phone: _____

EMAIL: _____@_____._____

Section 3

Father's Name:

FIRST

MIDDLE

LAST

Father's Home Phone: _____

Father's Mobile Phone: _____

Place of Employment: _____

Occupation: _____

Business Phone: _____

EMAIL: _____@_____._____

Student lives with: Mother Father Both Other

Person who has legal custody of child is _____

Section 4

Emergency Contact:

FIRST

MIDDLE

LAST

Home Phone: _____

Mobile Phone: _____

Place of Employment: _____

Occupation: _____

Business Phone: _____

EMAIL: _____@_____._____

Section 5

Proposed Start Date: _____
Christmas/ Easter/ Summer Term & Year

Proposed Location: _____

Section 6

Language (s) spoken at home: _____

Section 7

Indicate any medical problems by placing a circle around the appropriate condition:

- Asthma Respiratory ailments Chest problems Heart problems
- Migraine/ headaches Bladder problems Gastric problems
- Sting allergy Nut allergy Lactose intolerance Hay fever
- Vision impairment Hearing impairment Mobility ailment
- Diabetes Sickle Cell Epilepsy Kidney complaints
- Skin complaints

'Other' health complaints/problems: _____

'Other' description and any additional medical data: _____

Description of steps to be taken in the event of a medical emergency:

Please note that any medication to be administered during school hours must be accompanied with a signed note, outlining dosage instructions, time to be administered, etc. These forms are available at the front desk.

Special Dietary Needs: _____

Paediatrician's Name: _____

Paediatrician's Telephone Number: _____

Paediatrician's Cell Phone Number: _____

Section 8

Additional Information

Has your child ever been a recipient of a special services program?

PLEASE CHECK ALL THAT APPLY (If so please bring a copy of your child's evaluation).

Visual or Hearing Treatment

Physical Therapy

Speech Therapy

Behaviour Therapy

Other (please describe)

Section 9

Previous school (s) attended: _____

PARTICIPATION WAIVER:

As with any activity I understand that there may be risk of injury or harm. I agree to be responsible for any medical expenses incurred by my child(ren) while participating in sessions. I agree to hold the staff and volunteers of Fundaciones Limited, and their families, harmless from, and indemnify them for, any damage or loss arising as a result of my child(ren)'s participation in activities.

Parent/ Guardian Name: _____

Parent/ Guardian Signature: _____

Date: ___/ ___/ ___

This application must be submitted along with:

- Registration Fee of \$5000
- Copy of Health/ Immunization Records
- Copy of Birth Certificate
- Letter from Paediatrician