

ENROLLMENT FORM



IMPORTANT! To Submit Completed Forms:

1. Save this file as: Student Last Name_First Name_Required Forms
2. Email as an attachment to: office@mssl-edu.org
3. These forms MUST be received prior to first day of enrollment
4. Immunizations must be received before the child may attend

STUDENT INFORMATION

Student's Full Name _____ DOB _____

Name Student Prefers to be called _____ Gender: Male Female

Primary Address _____

City _____ State _____ Zip _____ Home Phone _____

Race/Origin: Caucasian Black or African-American Hispanic or Latino Asian
Pacific Islander American Indian None of the Above

Does your child currently nap? Yes No If yes, how long does your child nap? _____
(If your child is under the age of 5 years, they are required by state licensing to rest for a period of time.)

Child's T-Shirt Size: 2T 3T 4T YXS YS YM YL AXS AS AM AL AXL

PARENT OR GUARDIAN INFORMATION

Father or Guardian _____ Mother or Guardian _____

Home Address Same as student Home Address Same as student

Father's Address _____ Mother's Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Father's Cell Phone Number _____ Mother's Cell Phone Number _____

Father's Cell Phone Carrier _____ Mother's Cell Phone Carrier _____

Father's Email Address _____ Mother's Email Address _____

Father's Employer _____ Mother's Employer _____

Father's Occupation _____ Mother's Occupation _____

Father's Work Phone _____ Mother's Work Phone _____

Last Four Numbers of Father's SS# _____ Last Four Numbers of Mother's SS# _____

Child lives with: Both Parents Mother Father Other (please explain) _____

Who is responsible for the child's tuition? _____

EMERGENCY MEDICAL INFORMATION

In the event that neither parent can be reached, please list additional emergency contacts below in the order that contact should be attempted. Authorized persons will have to submit a copy of their driver's license as proof of identification for initial pick up.

First Contact _____ Relationship _____ Phone Number _____

Second Contact _____ Relationship _____ Phone Number _____

Third Contact _____ Relationship _____ Phone Number _____

MEDICAL HISTORY AND PROVIDER INFORMATION

Please list any allergies or dietary restrictions:

Does your child require an Epi-Pen? Yes No

Is your child asthmatic? Yes No

Does your child use an inhaler? Yes No

Is your child currently on any medications? Yes No

If yes, please list all medications _____

Insurance Carrier _____

Subscriber's Name _____

Group ID _____

Member ID _____

Pediatrician's Name _____

Pediatrician's Phone Number _____

Preferred Hospital _____

DISMISSAL APPROVAL

I authorize the following people to pick up my child from school. Authorized persons will have to submit a copy of their driver's license as proof of identification for initial pick up.

Full Name _____ Relationship _____ Phone Number _____

Full Name _____ Relationship _____ Phone Number _____

Full Name _____ Relationship _____ Phone Number _____

Full Name _____ Relationship _____ Phone Number _____

Full Name _____ Relationship _____ Phone Number _____

INFORMATION APPROVAL

It is imperative we maintain accurate, up-to-date information on each student enrolled in our school. Please review the information in this form to ensure we have the correct information on file. You may make changes directly in this document and submit to the office. We request parents to notify us immediately if there is a change in any information. This form must be signed and submitted to the office before your child may attend school.

By checking this box and typing your name below, you agree that all information provided is true and accurate.

Parent's Name _____ Date _____