ENROLLMENT APPLICATION (PLEASE PRINT)

Name of Child ______________________Date of Birth _______

Name Commonly Used ____________________________ Gender: [ ] Male [ ] Female

Local Address ___________________________________

Telephone ______________________

Mobile Phone ______________________

Email Address ___________________________________

Permanent Address____

Nationality________________ Child's Primary Language _________________

Other Languages _______________

PARENTAL INFORMATION

Mother's Name ___________________FATHER'S Name ____________________

Occupation _______________________ Occupation ________________________

Date of Birth_______________________ Date of Birth________________________

Place of Birth______________________ Place of Birth_______________________

Work Address ______________________ Work Address ______________________

_________________________________ _____________________________________

Work Telephone ___________________ Work Telephone _____________________

Emergency Contact and Phone(other than parent)___________________________

Other person(s) authorized to pick up child__________________________________

FOR OFFICE USE

Admission Date ______ Number of days ______ Registration Fee _____

Passport/Birth Certificate Copy _____

MEDICAL INFORMATION

Child's Name ______________________________ Date of Birth _____________
Mother's Name ____________________________ Phone __________________
Father's Name ____________________________ Phone __________________
Additional Emergency Contact ________________ Phone __________________
Doctor's Name ____________________________ Phone __________________

Medical Insurance Co. _______________________ Policy Number ___________

Child's Blood Type ______

Known Allergies _________________________________

Dietary Restrictions ____
Prescription Medications ____
Chronic Medical Conditions? ____
Pertinent Medical History ____

Medical Release

In the event of severe illness or injury to my child, __________________________, I hereby authorize and execute consent for emergency medical and hospital care and treatment, including major surgery, as deemed necessary by a duly licensed physician chosen by Green Tree Preschool & Academy staff. I understand that the Green Tree Preschool & Academy staff will take all safety precautions to protect my child, but cannot be held liable for any injury that my child incurs during school hours.

_______ ________________________________

Date Signature of Parent

List the dates for any of the following illnesses/conditions your child may have had:

ILLNESS		DATE
Anemia/chudokrevnost		
Asthma/astma		
Behavioral Problems/výchovné problémy		
Broken Bones/zlomeniny		
Chicken Pox/neštovice		
Diabetes/cukrovka		
Ear Infections/zánět ucha		
Epilepsy/epilepsie		
Fainting/mdloby		
Frequent Colds/časté nachlazení		
German Measles (Rubella)/zarděnky		
Hearing Difficulties sluchové problémy		
Heart Ailments/srdeční onemocnění		
Meassle (Red or Seven-Day)/spalničky		
Measles (Red or Seven-Day)/spalničky		
Pneumonia/zápal plic		
Polio/dětská obrna		
Roseola (Sixth Disease)/šestá nemoc		
Rheumatic Fever/revmatická horečka		
Scarlet Fever/spála		
Surgery/operace		
Tonsillitis zánět mandlí/angína		
Tuberculosis/TBC		
Whooping Cough/černý kašel		
Blood transmitted disease/krví přenosné nemoce		
Other/ostatní:		

Write dates of each vaccine received:

Immunization	Date	Date	Date
DPT/ záškrt-černý kašel-tetanus			
FSME/ klíšťová encefalitida			
Hepatitis A			
Hepatitis B			
HiB/haemophilus influenza typ B			
MMR/ zarděnky-příušnicespalničky			
Polio/děts okábrna			
Varicella/plane neštovice			
Meningitis/ meningitida			
Other			
Other			

Doctor Stamp Required