

# Mt. Helix Academy

Educational Excellence Through Measurably Superior Methods

## ENROLLMENT INFORMATION FORM

Child's name: \_\_\_\_\_ M  F  Resides with: \_\_\_\_\_  
Last First Middle Init.

Home Address: \_\_\_\_\_  
Street Apt# City Zip Code

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Grade enrolling in: \_\_\_\_ AIM HIGH: Y  N  No. of classes: \_\_\_\_  
Mo. Day Year

Child's ethnicity:  Caucasian  African Amer  Native Amer  Asian  Hawaiian/Pac Isl  Hisp/Latino  Mid Eastern  Filipino  Other  
check all that apply

Preferred manner of address

Mother: \_\_\_\_\_ ( ) \_\_\_\_\_  
Last First Middle Init. Dr. Ms. Mr. & Mrs. Other Home Telephone

Home Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
Only if Different: Street Apt# City Zip Code Work Telephone

E-mail Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
Cell phone

Occupation \_\_\_\_\_ Employer: \_\_\_\_\_

Mother's contact information may not be printed in the Mt Helix Academy Family Directory.

Preferred manner of address

Father: \_\_\_\_\_ ( ) \_\_\_\_\_  
Last First Middle Init. Dr. Mr. Mrs. Other Home Telephone

Home Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
Only if different from Mother's: Street Apt# City Zip Code Work Telephone

E-mail Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
Cell phone

Occupation \_\_\_\_\_ Employer: \_\_\_\_\_

Father's contact information may not be printed in the Mt Helix Academy Family Directory.

If Mother and Father are divorced or legally separated and there is a custody arrangement, please describe the arrangement and either (a) attach court document(s) to verify the arrangement or (b) both mother and father must sign this statement.

### EMERGENCY AND MEDICAL INFORMATION

In an EMERGENCY, if parents are not available, please notify the following persons:

|  |
|--|
| _____ ( ) _____ ( ) _____ ( )  |
| <small>Last Name First Name Home Telephone Work Telephone Cell Telephone</small> |
| _____ ( ) _____ ( ) _____ ( )  |
| <small>Last Name First Name Home Telephone Work Telephone Cell Telephone</small> |

Yes  No My child is allergic to medication.  
 If YES, please name the medication(s):

Identify any other conditions about your child that medical personnel should be aware of (e.g., asthma, bee sting allergy, seizures):

Identify any prescription medications regularly taken by your child.

Yes  No My child can be administered Tylenol at school if s/he is experiencing headache, toothache, or another minor ailment. I understand that each administration will be documented.

Yes  No I/we give permission for the school to post emergency information in the Mt. Helix Academy staff lounge.

**IF I AM UNAVAILABLE WHEN MY CHILD NEEDS TO GO HOME**

I give my permission for the following individuals, who are 18 years or older, to pick up my child from the school or receive my child from school staff in the event that he/she must be taken home and I am unavailable:

|           |            |                |                 |                 |
|-----------|------------|----------------|-----------------|-----------------|
| _____     | _____      | ( ) _____      | ( ) _____       | ( ) _____       |
| Last Name | First Name | Home Telephone | Other Telephone | Other Telephone |
| _____     | _____      | ( ) _____      | ( ) _____       | ( ) _____       |
| Last Name | First Name | Home Telephone | Other Telephone | Other Telephone |
| _____     | _____      | ( ) _____      | ( ) _____       | ( ) _____       |
| Last Name | First Name | Home Telephone | Other Telephone | Other Telephone |

Please provide the following information if applicable:

Stepfather's Name: \_\_\_\_\_  
Last First

Stepmother's Name: \_\_\_\_\_  
Last First

Sibling's Name: \_\_\_\_\_ D O B: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female.  
Last First Month Day Year

School: \_\_\_\_\_  
Name School Street Address City Zip Code

Sibling's Name: \_\_\_\_\_ D O B: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
Last First Month Day Year

School: \_\_\_\_\_  
Name School Street Address City Zip Code

Sibling's Name: \_\_\_\_\_ D O B: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
Last First Month Day Year

School: \_\_\_\_\_  
Name School Street Address City Zip Code

Please use this space if you need more room to answer any of the questions on this form

To whom should the following information be sent?

|  | Mother                   | Father                   | Other |
|--|--------------------------|--------------------------|-------|
| Admissions and Records information:    | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Statements regarding tuition and fees: | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| General School Mailings:               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

We have answered all of the items on this form accurately and provide all the permissions requested on the form. We accept responsibility for informing the administrative office of any changes in the information we have provided and acknowledge that the school's ability to provide for our child's health and safety may depend on the information provided.

|           |       |           |       |
|-----------|-------|-----------|-------|
| _____     | _____ | _____     | _____ |
| Signature | Date  | Signature | Date  |