

F.H.C.S. Public Montessori Schools Enrollment Form

www.fhcspto.org

Please Print

Student Name: _____ Home phone: _____

Legal last name if different: _____ Sex: _____

Physical Address: _____ Birthdate: _____

City: _____ State: _____ Zip: _____ Birth Place: _____

Mailing Address: _____ Social Security #: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Last School District Attended: _____ **Grade (2008-2009):** _____

Parent/Guardians Signature: _____

Full Name	Last	First	Student Lives With	Has Legal Custody	Place of Employment	Business Phone
Father						
Mother						
Stepfather						
Stepmother						
Legal Guardian						
Foster						

Emergency Contact Person: _____ Phone #: _____
Address: _____

If there is a Divorce or Legal Separation, please provide custody papers.

Home Language Survey:

What is the first language student learned? English Spanish Other
 What language does student speak most often? English Spanish Other
 What language is spoken most often at home? English Spanish Other

Race/Ethnic Background:

American Indian/Alaska Native Black Caucasian (White) Hispanic
 Pacific Islander or Asia

Mark if applicable:

<input type="checkbox"/> Gifted Program	<input type="checkbox"/> Special Placement in _____	<input type="checkbox"/> Needs help in _____
<input type="checkbox"/> Learning Disabled	<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Physically Handicapped
<input type="checkbox"/> Multiple Handicapped	<input type="checkbox"/> Hearing Handicapped	<input type="checkbox"/> Moderately Mentally Retarded
<input type="checkbox"/> Visually Handicapped	<input type="checkbox"/> Speech Handicapped	<input type="checkbox"/> Mildly Mentally Retarded
	<input type="checkbox"/> Emotionally Disabled	<input type="checkbox"/> Other

Medical History: Give Dates/Information

<input type="checkbox"/> Measles _____	<input type="checkbox"/> Mumps _____	
<input type="checkbox"/> Allergy _____	<input type="checkbox"/> Hearing Loss _____	<input type="checkbox"/> Convulsive Disorder _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Recent Ear Infection _____
<input type="checkbox"/> Chicken Pox _____	<input type="checkbox"/> Scoliosis _____	<input type="checkbox"/> Heart Condition _____
<input type="checkbox"/> Glasses _____	<input type="checkbox"/> Operations _____	<input type="checkbox"/> T.B. or Contact _____
<input type="checkbox"/> Physical Handicap _____	<input type="checkbox"/> P.E. Restrictions _____	<input type="checkbox"/> Daily Medication _____

Family Physician: _____ Address: _____ Phone: _____

FOR OFFICE USE ONLY

Administrative Office: L.E.A. District 101
15055 N. Fountain Hills Blvd., Fountain Hills, AZ 85268
Phone: (480) 837-0046 Fax: (480) 837-0024

Entry/Withdrawal Record				
Grade	Code	Date	School	SIRS

Date Records requested:

Date Records received:

Birth Certificate Other Immunization Complete
 Medical Alert Legal Alert Custody Papers on file