Blooming Stars Education Center

Mandarin-English Montessori Early Education Center

Face Sheet

Child's Information

First name | Middle name | Last name

Date of Birth | Primary language | Gender

Parent/Guardian Information

Name | Relationship

Home address | City | State | Zip

Home phone | Cell phone | Work phone

E-mail | Occupation | Company Name

Company Address

Parent/Guardian #2 Information

_____

Name Relationship

_____

Home address City State Zip

_____ _____ _____

Home phone Cell phone Work phone

_____ _____ _____

E-mail Occupation Company Name

_____

Company Address

Siblings

_____

Name age School

_____

Name age School

_____

Name age School

Other persons in household

_____

Name relationship

Medical History

Does your child have any learning or emotional difficulties? _____

Any speech or hearing difficulties? _____

Any physical difficulties of medical problems? _____

Allergies? _____

Any medications or special accommodations? _____

Physician Information:

_____

Name Phone Number(s)

_____

Address

Program Option

_____Early Drop-off (7:00am – 8:00am)

_____Full Day Program (8:00am – 6:00pm)

_____5 days/wk

_____4 days/wk

_____3 days/wk

_____2 days/wk

Desired state date:_____

Deposit: A non-refundable deposit $500.00 must accompany this form. Please make checks payable to **Blooming Stars Education Center**. Mail to: Blooming Stars Education Center, 470 Washington, Brighton, MA 02135.

I authorize Blooming Stars Education Center to include my e-mail on the classroom parent e-mail reports.

_____ _____

Parents/Guardian Signature Date