

Ս. ՊԵՏՐՈՍ ՀԱՅՅ. ԱՌԱՔԵԼԱԿԱՆ ԵԿԵՂԵՑԻ
ST. PETER ARMENIAN APOSTOLIC CHURCH
HONORING OUR PAST ☕ BUILDING OUR FUTURE

St. Peter Armenian Church Saturday Armenian School
ENROLLMENT APPLICATION
September 2025 - May 2026

First Day of School: September 6, 2025

* Please complete all fields

STUDENT INFORMATION

Last Name _____ First Name _____

Address _____

Date of Birth _____

☐ New Student

☐ Returning Student (Name of Prior Year Teacher) _____

Armenian dialect preference ☐ Eastern Armenian ☐ Western Armenian

PARENTS' INFORMATION

**** at least one E-mail address is required****

Father's Name _____

Address (if different than student) _____

Cell Phone Number _____

E-mail Address _____

Mother's Name _____

Address (if different than student) _____

Cell Phone Number _____

E-mail Address _____

Preferred Phone Number for school communication ☐ Father ☐ Mother ☐ Both

Preferred E-mail Address for school communication ☐ Father ☐ Mother ☐ Both

IN CASE OF EMERGENCY (besides parents)

Emergency Contact _____

Relationship _____ Phone _____

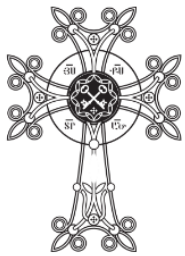
Special Notes _____

AUTHORIZED PEOPLE TO PICK UP CHILD

1) Name _____ Relationship _____ Phone _____

2) Name _____ Relationship _____ Phone _____

3) Name _____ Relationship _____ Phone _____



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EMERGENCY RELEASE FORM

I (We) the undersigned parent(s) or legal guardian of _____ D.O.B. _____ minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general supervision of any member of the medical staff and Emergency Room staff licensed under the provisions of the California Medicine Practice Act or a dentist licensed under the provisions of the dental Practice Act, and on the staff of any acute general hospital holding a current license for operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care, which the aforementioned physicians in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California.

PHYSICIAN'S NAME AND PHONE NUMBER _____

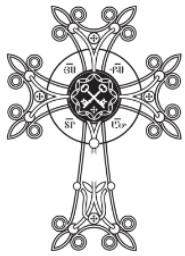
HEALTH INSURANCE CARRIER NAME _____ POLICY NUMBER _____

Any special medication taken/allergies or important information/comments:

I understand that emergency information is required by the St. Peter Church Saturday Armenian School for the release and treatment of my child for any problem requiring possible emergency action. It is my responsibility to notify the school IMMEDIATELY of any change.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PRINT PARENT NAME _____



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PHOTO RELEASE FORM

I hereby grant St. Peter Armenian Apostolic Church Saturday Armenian School permission to use my child (s) likeness in photographs and/or video in any and all of its publications, including Web space, and in any and all other media, whether now known or hereafter existing, **controlled by St. Peter Armenian Church**, in perpetuity, and for other use by the Saturday School. I will make no monetary or other claim against St. Peter Armenian Church Summer Program for the use of the photographs and/or video.

Student's Name (print full name)_____

Parent's Name (print full name)_____Signature_____

Date_____