



| Child's Information   |            |        |
|---|------------|--------|
| Name:   | Last Name: |        |
| DOB: (mm/dd/yyyy)   | Gender:    |        |
| Primary residence Address:  |            |        |
| City:   | Zip Code:  |        |
| Family Information /Guardianship  |            |        |
| Parent/Guardian 1 E-MAIL:   |            |        |
| Name:   |            |        |
| Address:  |            |        |
| City:   | Zip Code:  |        |
| Phone   | Work       | Mobile |
| Parent/Guardian 2 E-MAIL:   |            |        |
| Name:   |            |        |
| Address:  |            |        |
| City:   | Zip Code:  |        |
| Phone   | Work       | Mobile |
| Medical Information   |            |        |
| Has your child received vaccinations as recommended by the Surgeon General ?              | YES        | NO     |
| Does your child suffer from life threatening /anaphylaxis allergies                       | YES        | NO     |
| If yes, please specify:   |            |        |
| Does your child suffer from seasonal allergies?   | YES        | NO     |
| If yes, please specify:   |            |        |
| Is your child gluten, lactose or citiric intolerant? Does he have any other food allergy? | YES        | NO     |
| If yes, please specify:   |            |        |



*Apex Peak Schools Enrollment Form*

|  |     |                        |
|--|-----|------------------------|
| Has your child being diagnosed as having a particular condition  | YES | NO                     |
| If yes, please specify:  |     |                        |
| Has your child ever experienced or currently experiences seizures or fainting spells?  | YES | NO                     |
| If yes, please specify:  |     |                        |
| <b>Primary Physician Information /Hospital/ Insurance information</b>  |     |                        |
| Physician/Practice Name:   |     |                        |
| Address:   |     |                        |
| City:  |     | Zip Code:              |
| Phone  | PA: | PRN:                   |
| Insurance Provider:  |     | Policy Number          |
| Name of party insured:   |     | Relationship to child: |
| Emergency Care Information and authorization for medical transportation  |     |                        |
| Preferred Hospital   |     |                        |
| <b>Emergency Contacts, besides parent/guardians:</b>   |     |                        |
| Name:  |     |                        |
| Phone  |     | Mobile                 |
| Is this person authorized to pick up children from school or program activities? A valid government issued ID will be required.  | Yes | No                     |
| Name:  |     |                        |
| Phone  |     | Mobile                 |
| Is this person authorized to pick up children from school or program activities? A valid government issued ID will be required.  | Yes | No                     |
| I agree that the School may authorize other physicians to provide treatment, and request emergency transportation, in the event that neither I nor the persons listed above may be reached immediately.<br>Please SIGN and DATE: |     |                        |
|  |     |                        |



*Apex Peak Schools Enrollment Form*

**ABOUT YOUR CHILD**

Primary Language spoken at home:

Do you speak any other language with your child:

Place of your child in the family (only, first, last, middle)

Names and ages of siblings if applicable:

Please tell us 3 favorite things of your child, including favorite book and/or movie:

**PROGRAM ATTENDANCE and PAYMENT OPTIONS**

How many days per week, schedule and which days do you plan your child to attend our school:

No. of days \_\_\_\_\_

Preferred days:

Do you plan to pay tuition with a credit card?

Please provide the following information

Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ American Express \_\_\_\_\_

Name on Credit Card:

Credit card No: \_\_\_\_\_ CIS /CVN \_\_\_\_\_

Expiration Date:

Billing Address , **please include Zip Code**

Date: