

ALTERNATE PICK-UP PERSON(S)

List persons other than parent(s) or guardian(s) authorized to remove child(ren) from My School in Dover, NH

(1) Name _____ Relationship _____

Street _____ Phone _____

City _____ State _____ Zip _____

(2) Name _____ Relationship _____

Street _____ Phone _____

City _____ State _____ Zip _____

(3) Others _____

SCHEDULE

PRESCHOOL/PRE-K

Preschool (3 yrs.) ___ 2 days (T/Th) ___ 3 days (M/W/F) ___ 5 days

Pre-K (4 yrs.) ___ 2 days (T/Th) ___ 3 days (M/W/F) ___ 5 days

I will bring my child at ___ 7:30 am ___ 8:00 am ___ 9:00 am

I will pick my child up ___ 12noon ___ 1:00pm ___ 4:00pm ___ 5:00pm

Tuition is based on these times and are the only times available.

KINDERGARTEN (5 DAYS ONLY)

Kindergarten (5 yrs.) ___ 8:30am-12noon

Kindergarten (5 yrs.) ___ 8:30am-2:30pm

Child Care

Drop off ___ 7:30am

Pick-up ___ 1:00pm ___ 4:00pm ___ 5:30pm

READ AND SIGN

I understand that this schedule can only be changed with prior approval from the director _____ (signature/date)

OFFICE USE ONLY

Registration Fee _____ Date _____ Class _____

Schedule _____ Initial _____



My School

Established 1973

118 Locust Street, Dover, New Hampshire 03820

(603) 742-0321

Email: myskol@aol.com

www.myschooldover.com

For academic session beginning August 20 ___

For summer session beginning June 20 ___

The registration fee must accompany this application. A new application is required for each session your child is enrolled at My School. A health form is required before your child enters school. Returning students must have their health form updated. State requires **yearly** physical examinations.

I hereby understand and agree to adhere to information stated on this application, payment schedule, and other related policy forms. Enclosed is a **non-refundable** registration fee which will reserve a space for my child(ren).

Signature of parent

Date

FIRST MONTH'S TUITION DUE NO LATER THAN AUG. 1.

All information must be completed in detail yearly.

FAMILY INFORMATION:

Child's Name _____ Called _____ DOB _____

Street _____ Phone _____

City _____ State _____ Zip _____

What known allergies does your child have? _____

Parent's name _____ Phone _____

Street _____ City _____ Zip _____

While my child is in care, I can be contacted at:

Employer _____ Occupation _____

Business Address _____

Phone _____ Between the hours of _____

Special Instructions _____

Parent's name _____ Phone _____

Street _____ City _____ Zip _____

While my child is in care, I can be contacted at:

Employer _____ Occupation _____

Business Address _____

Phone _____ Between the hours of _____

Special Instructions _____

History

Child's present school _____ Phone _____

Address _____

Street

City

Zip

List previous schools attended

List names and ages of brothers and sisters

Hobbies & Interests

EMERGENCY LOCAL CONTACT PEOPLE

Person who can assume responsibility for child if parent or guardian can not be reached immediately in an emergency THIS MUST BE COMPLETED. People must be local and reachable.

(1) Name _____ Phone/cell _____

Address _____

Relationship _____

(2) Name _____ Phone/cell _____

Address _____

Relationship _____

MEDICAL EMERGENCY STATEMENT

I hereby give permission for **My School personnel** to give my child simple first aid when necessary, and to transport my child _____ to the nearest hospital or other emergency medical facility to receive emergency treatment. **My School personnel** may NOT administer medication of any kind. Do not send medicine to school.

Legal Guardian Signature

Date