



GERMAN LANGUAGE SCHOOL
AT GERMAN INTERNATIONAL SCHOOL NEW YORK

50 Partridge Road
White Plains, NY 10605
+1 914 948 6513 Ext. 203
+ 1 914 948 6529 Fax
languageschool@gisny.org
www.gisny.org/languageschool

REGISTRATION/ENROLLMENT AGREEMENT FOR 2018-2019 SCHOOL YEAR

GERMAN LANGUAGE COURSES: **WEDNESDAYS:** **4:15 PM - 6:30 PM**
 SATURDAYS: **9:30 AM - 12:00 PM**

Please indicate the course for which you are registering your child, and PRINT OR TYPE the following information:

STUDENT'S NAME: _____
 FIRST LAST 1 MALE 1 FEMALE

ADDRESS: _____
 STREET

 CITY STATE ZIP

HOME PHONE: _____ EMAIL: _____

DATE OF BIRTH: _____ CITIZENSHIP: _____
 MONTH/DAY/YEAR

PLACE OF BIRTH (City / Country): _____

FATHER'S NAME: _____ Cell Phone: _____

MOTHER'S NAME: _____ Cell Phone: _____

NAME/ADDRESS of American Day School: _____

GRADE LEVEL OF AMERICAN DAY SCHOOL STUDENT WILL ATTEND IN 2018-2019: _____

CAN STUDENT SPEAK, READ AND WRITE IN GERMAN? _____

IS GERMAN SPOKEN AT HOME? YES NO

DID STUDENT PREVIOUSLY RECEIVE GERMAN LANGUAGE INSTRUCTION? _____

NEW STUDENT AT GERMAN LANGUAGE SCHOOL? YES NO

I have read and am in agreement with the German Language School's Rules and Regulations for 2018-2019.

SIGNATURE: _____ DATE: _____
 PARENT OR LEGAL GUARDIAN MM/DD/YYYY

Tuition deposit \$300.00 due 5/15/2018 (non refundable).
NON REFUNDABLE REGISTRATION FEE \$150.00 due 5/15/2018 (for new students only).
Checks are to be made out to: **GERMAN INTERNATIONAL SCHOOL NEW YORK – Memo: Language School**

PLEASE FILL OUT THE EMERGENCY INFORMATION ON THE BACK OF THIS FORM ⇒



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EMERGENCY INFORMATION

School Year 2018-2019

NAME OF STUDENT: _____ Grade Level: _____

DATE OF BIRTH: _____ Social Security Number: _____
MONTH/DAY/YEAR (OPTIONAL)

NAME OF PARENT/S OR LEGAL GUARDIAN/S: _____

ADDRESS: _____

(STREET) (CITY) (STATE) (ZIP)

HOME PHONE NUMBER: _____ EMAIL: _____

BUSINESS PHONE NUMBER: _____
(MOTHER) (FATHER)

PARENT'S INSURANCE COMPANY: _____

POLICY NUMBER: _____

1. The school has my permission to call my family physician or another physician in an emergency when my family physician or I cannot be contacted.

2. NAME OF FAMILY PHYSICIAN: _____

TELEPHONE NUMBER: _____

3. The school has my permission in an emergency when I (or my physician) cannot be contacted to take my child to the emergency room of the nearest hospital, and the hospital medical staff has my authorization to provide treatment which a physician deems necessary for the well-being of my child. The original of this form shall be taken to the hospital with the patient.

SIGNATURE/S OF PARENT/S OR LEGAL GUARDIAN/S:

DATE: _____ (NOTARIZATION) _____