QSI INTERNATIONAL SCHOOL OF Malta
Triq Durumblat Mosta Malta MST 4815
phone: 00356 21423067 ; fax: 00356 21418213
justin-fischer@qsi.org www.qsi.org/malta/mlt

SURNAME _____**GIVEN NAME**_____

DATE OF BIRTH: _____/_____/_____ **SEX (M/F)** _____
Day Month Year

NATIONALITY: _____

SCHOOL LAST ATTENDED: _____

GRADE COMPLETED_____

NAME OF FATHER _____

NAME OF MOTHER _____

PHOTO

EXPECTED DATE OF ENTRY: _____ **IF AGE 3-4: HALF DAY / FULL DAY** **BUS: ROUND TRIP / MORNING/ AFTERNOON / NO BUS** **LUNCH: YES / NO**	**EMPLOYER FATHER**: **EMPLOYER MOTHER:**

TELEPHONE HOME/ MOTHER WORK	**FAHER TELEPHONE WORK**
MOTHER E-MAIL	**FATHER E-MAIL**
CELL PHONE MOTHER	**CELL PHONE FATHER**

HOME ADDRESS	**INVOICING ADDRESS**

PLEASE PROVIDE THE FOLLOWING INFORMATION WITH THIS APPLICATION **(* New Students Only)**

1. **GRADE REPORTS FOR PAST YEAR (7-YEAR OLD STUDENTS OR OLDER)***
2. **TRANSCRIPTS (Secondary STUDENTS ONLY)***
3. **LETTER OF RECOMMENDATION FROM PREVIOUS SCHOOL (IF AVAILABLE)***
4. PASSPORT OR BIRTH CERTIFICATE (ALL APPLICANTS)*
5. HEALTH FORM (ENCLOSED)*
6. Permission to publish telephone number in student directory **Y or N**
7. Permission to attend all school field trips (details distributed in advance) **Y or N**
8. Permission to use photos/ video recordings of your child during school activities **Y or N**
9. Permission to participate in school academic, athletic or cultural events (details in advance) **Y or N**
10. Permission to measure, record, gather, preserve and transfer student data using the **MAP** assessment. **Y or N**
11. **The school has permission to contact my child's or children's past educational institution to request school reports. Yes: _____ Decline: _____ Parent Signature: _____**

A non-refundable registration fee of $300 for each new student must accompany the completed application form.

_____ _____
Parent Signature Date

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HEALTH FORM

Child's Name and surname

_____

Allergies to medications_____

Other allergies (bees, peanuts, etc.)

_____

Medications taken regularly (list dosage)

_____

Chronic medical conditions or disabilities (ear infection, learning disability, etc.)

_____

Is your child limited in his/her ability to participate in school activities?

_____

Major illnesses or surgery_____

In case of a serious emergency and we cannot reach one of your contacts, please give the name of your physician, hospital, or ambulance service you wish to be called:

Physician: _____ Phone:_____

Hospital: _____ Ambulance: _____

In an emergency I authorize school authorities to take any steps necessary to administer medical treatment to my child (ren) in the event neither of the emergency contact persons can be reached.

_____ Yes _____ No

_____ _____

PARENT SIGNATURE