

**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

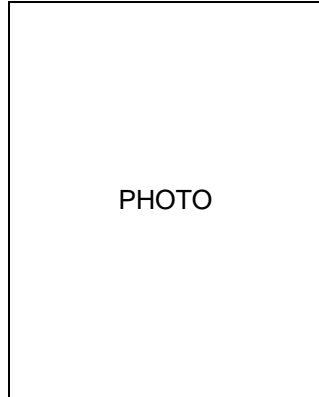
NATIONALITY: _____

SCHOOL LAST ATTENDED: _____

GRADE COMPLETED _____

NAME OF FATHER _____

NAME OF MOTHER _____



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

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

QSI INTERNATIONAL SCHOOL OF Malta

Triq Durumblat Mosta Malta MST 4815

phone: 00356 21423067 0035621418213

justin-fischer@qsi.org

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