



37 Park Street  
Fall River, Massachusetts 02721-1712  
Tel. 508-646-6410 Fax. 508-678-9743  
Robert Beatty, Executive Director

# Student Application

## Kindergarten

### 2010-2011

Atlantis considers all applicants without regard to race, color, religion, creed, gender, national origin, ethnicity, age, mental or physical disability, ancestry, athletic performance, sexual orientation, proficiency in the English language or foreign language, prior academic performance or any other legally protected status and such information provided in this application will not affect in any way eligibility for enrollment.

**Please contact Atlantis if you require this application to be offered in another language.**

**PLEASE PRINT AND COMPLETE ALL ITEMS ON THIS APPLICATION**  
**Parents/guardians will be contacted should the application be incomplete.**

#### STUDENT INFORMATION

Student's First Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student's Middle Name: \_\_\_\_\_ Gender (circle one): Male Female

Student's Last Name: \_\_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Street Address: \_\_\_\_\_ P.O. Box or Apt. No.: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work/Emergency: (\_\_\_\_) \_\_\_\_\_

E-mail address where family can be contacted: \_\_\_\_\_

Please send me school information via e-mail: \_\_\_\_ Yes \_\_\_\_ No

Name of school where student is currently enrolled: \_\_\_\_\_

Address of school: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

Grade student will attend in **2010 - 2011**: \_\_\_\_\_

Student's Place of Birth: \_\_\_\_\_ Student's Heritage: \_\_\_\_\_  
French, Lebanese, Portuguese, Puerto Rican

Race: (check all that apply)  American Indian  Asian  Black/Non-Hispanic  
 Hispanic  White/Non-Hispanic

What language is most often spoken at home? \_\_\_\_\_

Do you require school documents/meetings to be translated to another language? Yes \_\_\_\_ No \_\_\_\_

If so, which language? \_\_\_\_\_

Is the student receiving special education services based on a current Individual Education Plan (IEP): Yes \_\_\_\_ No \_\_\_\_

Is the student receiving Title I Services? Yes \_\_\_\_ No \_\_\_\_

Is the student eligible for the Migrant Education Program? Yes \_\_\_\_ No \_\_\_\_

**FAMILY INFORMATION**

Relationship: *mother, father, stepfather, stepmother, grandfather, grandmother, aunt, uncle, guardian, etc.*

Family Relationship \_\_\_\_\_

Family Relationship \_\_\_\_\_

First Name \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Last Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

P.O. Box or Apt. No. \_\_\_\_\_

P.O. Box or Apt. No. \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Parents are: *(please check)*    Married    Divorced    Separated    Widowed    Single

Custodial Parent(s):    Both parents    Mother    Father    Other \_\_\_\_\_

**BROTHERS AND SISTERS**

*As of September 2010*

Name \_\_\_\_\_   DOB \_\_\_\_\_   School Attending \_\_\_\_\_   Grade \_\_\_\_\_

Name \_\_\_\_\_   DOB \_\_\_\_\_   School Attending \_\_\_\_\_   Grade \_\_\_\_\_

**EMERGENCY CONTACTS**   (list **THREE** people who will assume temporary care of your child if you cannot be reached)

***ONLY THOSE INDIVIDUALS LISTED BELOW ARE ALLOWED TO PICK UP YOUR CHILD***

Relationship: *family member, friend, neighbor, etc. (do not include your own information again)*

Relationship \_\_\_\_\_   Relationship \_\_\_\_\_   Relationship \_\_\_\_\_

First Name \_\_\_\_\_   First Name \_\_\_\_\_   First Name \_\_\_\_\_

Last Name \_\_\_\_\_   Last Name \_\_\_\_\_   Last Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_   Phone (\_\_\_\_) \_\_\_\_\_   Phone (\_\_\_\_) \_\_\_\_\_

**MEDICAL INFORMATION**

Special medical conditions or allergies: \_\_\_\_\_

Medication: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_   Telephone \_\_\_\_\_

\_\_\_\_\_  
*Signature of Parent or Guardian*                      *Date*

**For school use only**  
Date Received \_\_\_\_\_  
Date Declined \_\_\_\_\_      Waiting List for next year?   Yes \_\_\_\_\_ No \_\_\_\_\_  
Date Enrolled \_\_\_\_\_

**For school use only**  
  
**Application must be returned to the  
Family Learning Center**