



# JAKARTA MONTESSORI SCHOOL

## REGISTRATION FORM

Photo of Student  
(Max 4 x 6 cm)

Term of Entry : \_\_\_\_\_

**Child's Full Name** : \_\_\_\_\_

Place & Date of Birth : \_\_\_\_\_

Nationality & Religion : \_\_\_\_\_

Address : \_\_\_\_\_

Tel. / Fax No. : \_\_\_\_\_

**Father's Name** : \_\_\_\_\_

Place & Date of Birth : \_\_\_\_\_

Nationality & Religion : \_\_\_\_\_

Company's Name : \_\_\_\_\_

Position : \_\_\_\_\_

Company's Address : \_\_\_\_\_

Company's Tel/Fax No. : \_\_\_\_\_

Mobile No. : \_\_\_\_\_

E-mail Address : \_\_\_\_\_



# JAKARTA MONTESSORI SCHOOL

**Mother's Name** : \_\_\_\_\_  
Place & Date of Birth : \_\_\_\_\_  
Nationality & Religion : \_\_\_\_\_  
Company's Name : \_\_\_\_\_  
Position : \_\_\_\_\_  
Company's Address : \_\_\_\_\_  
Company's Tel/Fax No. : \_\_\_\_\_  
Mobile No. : \_\_\_\_\_  
E-mail Address : \_\_\_\_\_

## Emergency Contact Person

Name : \_\_\_\_\_  
Tel. / Mobile No. : \_\_\_\_\_

## Details of School previously attended by your child

Name of School : \_\_\_\_\_  
Address & Tel. No. : \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date



# JAKARTA MONTESSORI SCHOOL

## CHILD'S MEDICAL RECORD

Child's Full Name	:	_____
Sex	:	_____
Date of Birth	:	_____

**Child's Medical Practitioner**

Doctor's Name	:	_____
Address & Tel. No.	:	_____
		_____

Record of infectious Diseases	:	_____
Record of Allergies	:	_____

Are there any other medical facts of which the school should be aware? Yes ( ) No ( )  
*(If you have ticked YES, please give details in the space below)*

\_\_\_\_\_

In case of EMERGENCY, do we have your permission to take your child to the nearest clinic?  
Yes ( ) No ( )

RECORD OF VACCINATIONS AND IMMUNISATIONS :

<input type="checkbox"/>	BCG
<input type="checkbox"/>	DIPHTHERIA
<input type="checkbox"/>	PERITINITUS (WHOOPIING COUGH)
<input type="checkbox"/>	TETANUS
<input type="checkbox"/>	POLIO
<input type="checkbox"/>	MEASLES
<input type="checkbox"/>	MUMPS
<input type="checkbox"/>	REBELLA
<input type="checkbox"/>	HIB (MENINGITIS)
<input type="checkbox"/>	HEPATITIS A
<input type="checkbox"/>	HEPATITIS B
<input type="checkbox"/>	TYPHOID
<input type="checkbox"/>	VARILRIX (CHICKEN POX)

Signature of Medical Practitioner / Parent

Date



# JAKARTA MONTESSORI SCHOOL

## **PERMISSION SLIP FOR PHOTOGRAPHING / VIDEOING CHILDREN AT JAKARTA MONTESSORI SCHOOL**

There are many occasions where we are asked for photographs or videos of your children working in the Montessori School. The requests come from television stations, magazines, books and our own student teachers. The photo/videos will only be used for our school promotion material and Montessori related magazines and books. We would therefore like to ask your permission to include your child's photo, when working, in any of the above-mentioned requests. We always ask that all photographs / videos are acknowledged as from Jakarta Montessori School but no names of actual children are ever given.

- I give permission for my child \_\_\_\_\_  
to be photographed / videoed during school hours any time  
throughout his/her time at Jakarta Montessori School
- I do not give permission for my child \_\_\_\_\_  
to be photographed / videoed during school hours any time  
throughout his/her time at Jakarta Montessori School

\_\_\_\_\_  
Name of parents

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date