Application for the 2017-2018 school year

Student's name:		Date of Birth (mm/dd/yyyy):
Swedish Person- or samordnings#:		Grade at American school (2017/18):
Street Address:	City:	State, Zip Code:
Home phone:	E-mail:	E-mail may be used as primary form of communication: Yes___ No___
Mother's Name:	Mother's cell phone:	Mother's work phone:
Father's Name:	Father's cell phone:	Father's work phone:
Swedish citizenship: Mother: ____ Father: ____ Child: ____		
In case of an emergency call: 1) _____ ___ Phone:_____ 2) _____ ___ Phone:_____		
People other than parent that may pick up my child without written permission: 1) _____ 2) _____		

SWEDISH LANGUAGE BACKGROUND
My child: ___ speaks Swedish ___ understands Swedish ___reads Swedish ___writes Swedish

Is Swedish spoken on a daily basis in the home? Yes___ No___
If yes: by mother____ by father____ by both parents____ If no, what type of exposure does child get to Swedish?_____ _____ Please comment on child's knowledge of the Swedish language (according to age): _____ _____

Please check which committee you are interested in (see separate information):

Financial: ___ School activities: ___ Fundraising: ___ Marketing: ___

Substitute teacher: _____ (if so, please indicate for which age group)_____

Other interests or skills that I would like to share with the school: _____

_____

Tuition

$205/fall semester $245/spring semester $425/school year if paid in full at beginning of school year.

A discount of $25 is given to siblings of a full paying student.

Due dates	payment for fall semester	September 17
	payment for spring semester	December 20

*For returning students only: Please note that there is a surcharge of $25/child for payments not received by the due date. For payments not received by October 1st and January 10th respectively, there is additional charge of $50/child.

We aim to include all families regardless of financial situation. Please contact Kristina Vasandani for financial assistance consideration. Phone: 347-931-7159 e-mail: haggstromk@gmail.com

Please mail check, payable to Swedish Cultural Association of Hudson Valley, to:

Kristina Vasandani

47 Mulberry Lane

New Rochelle, NY 10804

I hereby enroll my child in the Swedish School for: Fall 2017: ____ Spring 2018: ____

School year 2017/2018 _____

If you do NOT want your child to appear in photographs on the Swedish School's website or in marketing material,

please check the following box ☐

Signed: Date:

Liability Release

Every activity that is sponsored by the Swedish Cultural Center of Hudson Valley is carefully planned and adequately supervised by mature adults. Even so, unforeseen events or accidents may occur. By signing this form, the below indicated parent, guardian or legal representative of the child or children named herein signifies that he or she fully understands the school activity participated in, and accepts all risks hazards inherent in such school activity.

Further, the below indicated parent, guardian or legal representative of the child or children named herein agrees to hold harmless the Swedish Cultural Center of Hudson Valley, its employees, board members or volunteer assistants from any and all liability for damages, losses or injuries to the person or property of any child or children named herein caused as acts or omissions amounting to simple negligence and to refrain from instituting any cause of action against any volunteer or person employed by the Swedish Cultural Center of Hudson Valley, to recover losses, whether medical or otherwise arising from acts or omissions amounting to simple negligence in any court in the State of New York.

Signature:_____ Date:_____

Printed Name:

SWEDISH CULTURAL CENTER of HUDSON VALLEY

MEDICAL INFORMATION

If any of this information should change during the school year, please notify the teacher in charge of you children.

Child's name: DOB:

Address:

City: State: ____ Zip:

Parent(s) name(s): Phone:

Doctor: City: Phone:

Health History:

Allergies:

Other Conditions:
Heart condition: ___ Frequent colds: ___ Hay fever: ___
Chronic asthma: ___ Frequent stomach upsets: ___ Epilepsy: ___
Physical handicap: ___ Diabetes: ___ Other: ___
If you checked any of the above, please give details (i.e. include normal treatment of allergic reactions):

Please note that your health insurance carrier will be billed for medical charges in the case of illness or injury while your child/children is at school or at school related activity.

Health insurance: Policy #:
Name of insurance holder:
Address:

At the event that I cannot be reached in an emergency, I hereby give my permission to the Physician or dentist selected by the school to hospitalize, to secure proper treatment, and/or order an injection, anesthesia, or surgery for my child as deemed necessary.

Signature: Date:

Printed name: