THE ARCHANGEL MICHAEL
GREEK LANGUAGE INSTITUTE
100 Fairway Drive • Port Washington, NY 11050
516-944-3183 | gli@archangelmichaelchurch.org
www.ArchangelMichaelChurch.org

Registration Form School Year 20__–20__

Student's Name **Please select one:** Session I Session II

Greek and/or Baptismal Name

Complete Address

Home # **Date of Birth**

Language(s) spoken at home

Day School attending Sept. 20__ **Grade**

Has your child attended Greek School prior to this year? Yes No

If yes, where? Grade as of September 20__

(If anywhere other than the Archangel Michael Greek Language Institute, please furnish a transcript of the records.)

Mother's Name: **Email:**

Home # Work # Cell #

Father's Name: **Email:**

Home # Work # Cell #

If my child is ill or an emergency situation occurs and my child must be taken home, I give permission for the following individuals to be called and my child released to them:

Name/Relationship

Phone

Name/Relationship

Phone

Physician's Name Phone

I give permission to have my child taken to the hospital in case of emergency:

Parent's Signature Date

Please describe any allergic reaction or medical condition that the School should be aware of. Also include any other information about your child that you feel is of importance:

We have read the information in the Archangel Michael Greek Language Institute Information Packet and agree to follow its rules and regulations.

Parent's Signature ______________________ Date __________

PLEASE NOTE THAT WE WILL BE PHOTOGRAPHING EVENTS AND PUBLISHING THOSE PHOTOS ON THE CHURCH WEBSITE AND IN CHURCH PUBLICATIONS. IF YOU DO NOT WISH FOR US TO USE YOUR OR YOUR CHILD'S NAME, IMAGE OR LIKENESS, YOU MUST FILL OUT THE NON-CONSENT FORM AVAILABLE AT REGISTRATION AND AVAILABLE ONLINE AT: WWW.ARCHANGELMICHAELCHURCH.ORG/NONWAIVERFORM.PDF