



Linden
PREPARATORY

Registration for Services

Child's Last Name: _____ First Name: _____
Date of Birth (mm/dd/yy): _____ Phone: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Child's Age as of Today: Years: _____ Months: _____ Child's Grade as of September 1st: _____
School Child Attends in September: _____

Family Information

List of Siblings at Linden : _____
Mother's Name: _____ Father's Name _____
Billing Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Mother's Business Name: _____ Business Phone: _____ Cell: _____
Father's Business Name: _____ Business Phone: _____ Cell: _____
Mother's E-mail: _____ Father's E-mail: _____
Parent's Marital Status (Check all that apply): Married Divorced Separated Mother Remarried Father Remarried
Child's Physician: _____ Phone: _____
Allergies: _____ Does your child require an EpiPen: _____

Emergency Contact Other Than Parents: Name: _____ Phone: _____
Father Authorized to pick up Child: Yes No Mother Authorized to pick up Child: Yes No
Other persons authorized to pick up child: 1. _____ 2. _____

Areas of Guidance: Review Educational Evaluation Attention and Focus ADHD Guidance Working Memory Behavior
 Learning Disabilities Family Organization Social Tutoring
Additional Areas of Focus: _____

I consent for my Child _____ to begin services at Linden Prep

Signature _____ Date _____

Submit

EILEEN VENTO, M.S.
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SOUTH MIAMI DIRECTOR

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