

**Montclair State University - Gifted & Talented Program**  
**Fall 2010 – Student Application**  
**October 2nd/3rd through December 4th/5<sup>th</sup> (excluding Nov. 27<sup>th</sup>/28<sup>th</sup>)**  
**Deadline: September 25th**  
**Personal Information**

First time enrollment? (please circle)      YES                      NO      If yes, eligibility documentation required (See page 2)

Enrolled Spring 2010 or Summer 2010:      YES                      NO      If yes, eligibility documentation not required (See page 2)

All applicants who did not attend Spring 2010 or Summer 2010 must submit eligibility documentation. (See page 2)

How did you learn about this program? Word of Mouth \_\_\_\_\_ Postcard \_\_\_\_\_ News-Media \_\_\_\_\_ On-Line \_\_\_\_\_

Teacher \_\_\_\_\_ Other (please explain): \_\_\_\_\_

Student's Name (First/Last): \_\_\_\_\_

Address (Street): \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: (      ) \_\_\_\_\_ Parent Email Address: \_\_\_\_\_

Birth Date (Month/Day/Year): \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Current Grade: \_\_\_\_\_

School Name: \_\_\_\_\_

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

School City/State/Zip: \_\_\_\_\_

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Name of Parent or Guardian: \_\_\_\_\_

Relationship: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

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# Fall 2010 Method of Payment

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Please make your tuition payment payable to: **Montclair State University  
Gifted & Talented Program  
One Normal Avenue  
Montclair, NJ 07042**

Or You May Fax Your Application to: **(973) 655-7895**

Circle method of payment: MasterCard    Visa    Check    Money Order  
**(We do not accept American Express or Discover)**

Credit Card/check or money order number: \_\_\_\_\_

Expiration Date: (Month/Year): \_\_\_\_\_

Name of Credit Card Holder: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Amount to be charged: Please circle number of classes:

1 Class . . . . .	\$325.00
2 Classes – (includes a double period) . . . . .	\$625.00
3 Classes . . . . .	\$900.00

Sibling Discount: \$-\_\_\_\_\_

Two or more children from the same family are each eligible for a 10% tuition discount of \$32.50 for one class, \$62.50 for two classes and \$90.00 for three classes

Faculty/Staff/Alumni Discount. . . . . \$-\_\_\_\_\_

Faculty/Staff/Alumni are entitled to a 15% discount (\$48.75 one class/\$93.75 two classes/\$135.00 three classes)

MSU NetID: \_\_\_\_\_

\*Parent Alumni must submit proof of degree (diploma/transcript, indicating degree awarded)

Total Amount of Tuition Due: \$ \_\_\_\_\_

Media Consent: We occasionally take photos during classes to be considered for our newsletters or other public media including our website. Do you give us permission to use your child's image? \_\_\_\_\_ Yes \_\_\_\_\_ No

Written notice of withdrawal will entitle registrants to a refund (less a \$40.00 non-refundable registration fee for one course and \$80.00 for two or three courses) provided such notice is postmarked prior to the first weekend of classes. No refunds will be made after the program begins.



Please indicate the session your child is attending: Saturday \_\_\_\_\_ Sunday \_\_\_\_\_

Please indicate the appropriate grade level: Grade (Fall 2010) \_\_\_\_\_

**This form must be completed for each child enrolling.**

(Please Print)

Student's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Age: \_\_\_\_\_

**Medical History Information:**

Does your child have any allergies to food? NO \_\_\_\_\_ YES \_\_\_\_\_

If Yes, please list

foods: \_\_\_\_\_

Does your child have any allergies to insect bites? NO \_\_\_\_\_ YES \_\_\_\_\_

If Yes, please list type of insect and allergic reaction: \_\_\_\_\_

Does your child carry an Epi-Pen or other type of medication treatment for the above allergies? NO \_\_\_\_\_ YES \_\_\_\_\_

Does he/she know how to administer this treatment? NO \_\_\_\_\_ YES \_\_\_\_\_

Is your child currently on medication that will need to be taken during program hours? NO \_\_\_\_\_ YES \_\_\_\_\_

If yes, please list medications and scheduled times: \_\_\_\_\_

Does your child have any medical conditions that we should be aware of if care is needed – (for example asthma, seizure disorder, bleeding disorder)? NO \_\_\_\_\_ YES \_\_\_\_\_

If Yes, please list: \_\_\_\_\_

**ACKNOWLEDGMENT OF RISK AND CONSENT FOR TREATMENT:** I, the undersigned, hereby acknowledge that certain risks of injury are inherent to any children's program, including but not limited to participation in classroom, recreational activities, sporting activities, lesson/laboratory experiments, transportation to, from the program, child's failure to follow instructions of supervisors, communicable illness, and independent acts of third parties not under the control of supervisors. I acknowledge that all risks cannot be prevented, and assume those beyond the control of the University staff. These types of injuries may be minor or serious and may result from one's actions, or the actions or inactions of others or a combination of both.

I will take responsibility to see that my child is prepared for all activities and is in good health each day of the session. I hereby assume all risks associated with participation in Montclair State University's Academically Gifted and Talented program and agree to hold harmless Montclair State University, its Academically Gifted and Talented Program, its directors, officers, employees, agents, representatives, counselors, volunteers, et al from and against any and all claims, demands, losses or liability of any kind or nature which may arise in connection with injuries suffered to my child while enrolled/participating in Montclair State University's Academically Gifted and Talented program.

In case of medical emergency, I understand that every reasonable attempt will be made to contact me or the emergency contact named below. However, in the event that I or my named contacts cannot be reached, I give my permission to the adults in charge of the Gifted and Talented Programs to secure and receive emergency medical or first aid treatment for my child, including transport via ambulance to a hospital if necessary. I consent to the sharing and release of any medical information listed above with the appropriate staff members of the Gifted and Talented program and/or medical personnel that may be necessary to ensure the safety and wellbeing of my child. I agree to pay for any charges for emergency medical treatment that are not covered by my personal health insurance. I have read and understand the above informed consent agreement in its entirety and hereby give my consent for the registrant to participate knowing all of the foregoing.

\_\_\_\_\_  
Parent/Guardian Name (please print) Parent/Guardian Signature (required) Date

Parent or Guardian: \_\_\_\_\_

Relationship: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_