



Application checklist

- Application
- Child's application
- Family support information
- Student health information

*Submit forms to: Mandala School, 738 Main Street, East Aurora, NY 14052
or as email attachments to: DrJohn@MandalaSchool.org*

Parent/Guardian Application

Child's Name _____

Why are you choosing Mandala?

Please describe any of your child's special interests, talents, & skills:

Describe any particular challenges your child has:

Describe challenges you want your child to have:

At Mandala we encourage self-discipline and self-motivation. Part of most days is open time for students to work on their own interests. Are you comfortable with this approach to learning?

Do you think your child will take advantage of these times of choice?

Add any additional comments you wish:

Child's Application

(page 1 of 2)

Your name: _____

Describe some of your favorite learning experiences:

What do you wonder about?

Child's Application

(page 2 of 2)

Your name: _____

What do you like to do when you have free time?

Describe a friend of yours:

Tell us anything about yourself you want to add:

Family/School Connection

Which times are better for you to help with maintenance and cleaning? evenings weekends
(Everybody needs to contribute time for maintaining the space and keeping costs down.)

What special talents & skills are you willing to share:

Please check any areas with which you can help:

- Grant writing
- Fundraising events
- Securing special guests
- Overnight field trips
 ___ single night ___ multi-night
- Parent/family liaison (organize clean-up days, meetings)
- General maintenance (painting, minor repairs, lawn work)
- Skilled work
 - ___ plumbing
 - ___ electrical
 - ___ carpentry
 - ___ roofing
 - ___ computer programming

Child's Name	<i>Student health information</i>
Street	
Town & zip code	

If the above people can not be reached, what other person may be called?

parents/guardian names	Address (if different from above)	phone numbers/email

Name	Relationship	Telephone
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Child's Medical Information

Date of Birth: _____ Age _____ Sex M F Ht _____ Wt _____

Any dietary restrictions:

Any adverse reaction to medication:

Any medications child is currently taking:

Family Physician	Telephone
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Restrictions to student's activities advised by physician:

Other medical concerns or problems (explain):

Date	Signature (Parent or Legal Guardian)
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