



Clara Mohammed Elementary/W. D. Mohammed High School
 735 Fayetteville Road, Atlanta, Georgia 30316
 (404)378-4219 * Fax: (404)378-4600 * (404)378-1042 * Fax: 404)378-2113



RE-ENROLLMENT FORM

School Year _____
 Grade Entering _____

Student Information

Student's Full Name _____
Last First Middle Name Student Prefers

Address _____ Phone _____

City _____ State _____ County _____ Zip _____

Social Security Number _____ - _____ - _____ Date of Birth _____

Sex: Male Female E-mail Address: _____

Student's Ethnic Background: African-American Asian Caucasian Hispanic Native American Bi-Racial
 African Ethiopian Nigerian Middle Eastern Other (explain) _____

Student lives with: Both Parents One Parent Stepmother Stepfather Grandparents Guardian
 Other (Explain)

Family Information

Father's Name (or legal guardian) _____ Mother's Name (or legal guardian) _____

Relationship (if guardian) _____ Relationship (if guardian) _____

Address (if different from Student) _____ Address (if different from Student) _____

Phone # (if different from student) _____ Phone # (if different from student) _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Business Phone _____ Business Phone _____

E-mail Address _____ E-mail Address _____

Educational Background

Please indicate your highest level of education:

Mother HS Diploma College/degree or diploma Graduate or Business Study Technical/degree or diploma
 Father HS Diploma College/degree or diploma Graduate or Business Study Technical/degree or diploma

Financial Status: Family Income (Please check the one that applies)

\$0-\$19,000 \$19,001- \$25,900 \$25,901-32,560 \$32, 561-\$45,880 \$45,881-\$59,200 \$59,201-\$75,660
 \$75,661- \$95,860 \$95,860+



RE-ENROLLMENT FORM

Do you have other children enrolling in Mohammed Schools: yes no

Please list their name and grade entering:

Name _____ DOB _____ Grade _____

Emergency Information

Emergency Contact : _____
Name Relationship to Student

Phone# Cell #

Emergency Contact : _____
Name Relationship to student

Phone# Cell #

The school is authorized to release this student to the following individuals for after school pickup.

(Name) (Relationship) (Phone)

(Name) (Relationship) (Phone)

(Name) (Relationship) (Phone)

(Name) (Relationship) (Phone)

Please complete the following items to provide school personnel with essential information should an emergency prevent you from access to your child. This information will be shared only with individuals who have a need to know.

Medical Conditions: _____

Medications required (note frequency): _____

Allergies (note especially allergies to food or medicines): _____

Physician's Information: Name _____ Phone _____

Address _____

Parent Signature

Date