



*Ecole Française du Samedi*  
**Academic year 2024- 2025**

**Student's information:**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
D.O.B: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Age next September: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
City: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Grade in US school next September: \_\_\_\_\_ Name of school: \_\_\_\_\_  
(Please circle) French as first language:    yes    no    French as second language:    yes    no

**Guardian 1**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
Cell: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Language spoken with guardian 1:  
1) \_\_\_\_\_ 2) \_\_\_\_\_  
Email: \_\_\_\_\_  
Employer's company name: \_\_\_\_\_

**Guardian 2**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
Cell: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Language spoken with guardian 2:  
1) \_\_\_\_\_ 2) \_\_\_\_\_  
Email: \_\_\_\_\_  
Employer's company name: \_\_\_\_\_

**Picture release authorization form:**

I authorize the French Saturday School / Language Academy to release pictures of my child(ren) on the website,  
Facebook page, youtube or any other media support related to the school.  
NO name will be associated with a picture for privacy.    **YES**    **NO**    ( Please circle)

Signature 1: \_\_\_\_\_ Signature 2: \_\_\_\_\_

[info@ecolefrancaisedusamedi.org](mailto:info@ecolefrancaisedusamedi.org) / [www.the.languageacademynj.org](http://www.the.languageacademynj.org) / Phone: 862-266-9716

Facebook.com/frenchsaturdayschool / Mail to: FSS PO Box 573 Succasunna, NJ 07876



Please send this form with a \$350 non-refundable check per child.

Reservation is only confirmed upon payment.

Application after the deadline February 10th, 2024 will be reviewed on a space-available basis.

\$100 discount per child, for registration before February 10th 2024.

5% discount for second child 10% for third child. **Installment payments on request.**

Tuition and fees are due for the entire year (even if monthly installment payments are installed)  
and are not refundable under any circumstances.

Checks are payable to **French Saturday School.**

Tuition 2024 - 2025		Please circle	Please circle
Administration Fee + school supplies: one per child			\$200
<b>Saturday / 33 classes / September to June.</b>			
Classe de Maternelle / <b>Maternelle class:</b> Children aged 3 - 6. French Class 8:15 AM - 11 am			\$3,000
Classe de CP/Ce1 / <b>Grade 1 / 2</b> French Class 8:15 AM - 11 am			\$3,150
<b>Ce2 to CM2</b> French class: 11:00 pm - 1 pm Culture générale / reading comprehension 1 pm - 2 pm)			\$3,000 \$250
<b>6eme to 3eme</b> French class: 11:00 pm - 1:00 pm Culture générale / reading comprehension 1:00 pm - 2 pm)			\$3,300 \$250
<b>Weekly classes: 4 PM to 6 PM</b>			
<b>Friday</b>	Elementaire - college / <b>Elementary -Middle school</b> 4 PM- 6 PM		\$2,850
<b>Friday</b>	Maternelle / <b>PS - GS - GS</b> 4 PM to 6 PM		\$2,850
<b>\$100 discount per child, for registration before February 10th 2024.</b>			
<b>Discount 5% for siblings.</b>			
<b>TOTAL (Registration fee + Tuition - Eventual 5% siblings discount...)</b>			

Signature 1: \_\_\_\_\_ Signature 2: \_\_\_\_\_

Date: \_\_\_\_\_



**French Saturday School Academic year 2024 -2025**

**Student's first name:** \_\_\_\_\_ **Last name:** \_\_\_\_\_

**Date of birth:** M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** F M

**Emergency contact phone number:** \_\_\_\_\_ **Name:** \_\_\_\_\_

*(Please write clearly)*

**Allergies and know medical condition:**

**Medical release:**

I hereby release, discharge and - or otherwise indemnify Language Academy (LA) / French Saturday School (FSS), its affiliated Organizations and sponsors, their employees and associated personnel, including the owners of the facilities utilized for the program, against any claim by or on behalf of the student's participation in the school.

My child has received a recent physical examination by a physician and I have disclosed any and all know medical conditions to the French Saturday School. Therefore, I grant The French Saturday School permission to act as my surrogate for my child in the area of obtaining medical treatment by a doctor of medicine or dentistry. I give permission to have my child receive first aid by the French Saturday School staff and, if necessary, be transported to receive emergency care. I consent for the emergency contact person listed above to act on my behalf until I am available. I understand that I will be contacted immediately should my child require urgent medical attention.

In the event that I can not be reached, I give permission to the authorities of LA / FSS to seek emergency treatment at the nearest hospital. I also assume financial responsibility for any medical treatment for my child. I understand that I will be responsible for all charges not covered by their own insurance.

**Primary doctor's name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance Information:** Name \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_