



# KIDS TINKERING STUDIO LTD

the STEM people.

# 74 LUIS STREET WOODBROOK TRINIDAD WEST INDIES

PHONE:1 868 242-1863/ 713-7492 WEBSITE: KIDSTINKERINGSTUDIO.COM

## APPLICATION FOR ADMISSION

### Application Procedure

The following steps are necessary for applicant to be considered for admission:

- Fill this form and submit via email to [kidstinkingstudio@gmail.com](mailto:kidstinkingstudio@gmail.com).
- Pay the application fee of \$200 TT and Assessment Fee \$400TT via Online Transfer or Bank Deposit to the following account:  
**Account name: Kids Tinkering Studio Ltd.**  
**Account Number: 2565011**  
**Checking account**
- Email a copy of the receipt to [paymentskidstinkingstudio@gmail.com](mailto:paymentskidstinkingstudio@gmail.com)
- Parents or guardians will then be contacted to schedule an interview with a Director of the School and to have your child's Assessment done.

<b>Father's Complete Name:</b>				
<b>Home Address:</b>				
<b>Home Phone:</b>		<b>Email:</b>		
<b>Occupation:</b>		<b>Cell:</b>		
<b>Marital Status:</b>	<b>Single</b>	<b>Married</b>	<b>Divorced</b>	<b>Widowed</b>
<b>Languages spoken:</b>				
<b>Mother's Complete Name:</b>				
<b>Home Address:</b>				
<b>Home Phone:</b>		<b>Email:</b>		
<b>Occupation:</b>		<b>Cell:</b>		
<b>Marital Status:</b>	<b>Single</b>	<b>Married</b>	<b>Divorced</b>	<b>Widowed</b>
<b>Languages spoken:</b>				

## INFORMATION ON THE CHILD

<b>Name Of Child:</b>	<b>M</b>	<b>F</b>
<b>Date of Birth: (dd/mm/yyyy)</b>	<b>Place of Birth:</b>	
<b>Nationality:</b>	<b>Age:</b>	<b>Religion</b>
<b>With whom does he/she live?</b>		
<b>Address:</b>		
<b>Do you know a family that has children in Kids Tinkering Studio? Yes No</b>		
<b>Why have you chosen Kids Tinkering Studio as an educational option for your child?</b>		
<b>Language Spoken</b>		

## MEDICAL HISTORY

<b>Any health conditions?</b>
<b>Any physical limitations/disabilities?</b>
<b>Any special recommendations for the child's adaptation to the school:</b>
<b>Other (specify):</b>

<b>IN CASE OF EMERGENCY PLEASE CALL:</b>	
<b>Name:</b>	<b>Phone:</b>
<b>Name:</b>	<b>Phone:</b>
<b>Pediatrician or family physician:</b>	
<b>Phone:</b>	
<b>Hospital:</b>	

We the undersigned declare that all the information provided in this form is correct and true.

The application form will be declared null and void in the case of incorrect information.

Date \_\_\_\_\_, \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_

SIGNATURE OF THE FATHER

\_\_\_\_\_

SIGNATURE OF THE MOTHER