

## APPLICATION FOR ENROLLMENT

Enrollment date requested \_\_\_\_\_ Today's Date \_\_\_\_\_

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Age \_\_\_\_\_

### **Family Information:**

Father/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_ NC Driver's License # \_\_\_\_\_

Where Employed \_\_\_\_\_ Business Phone \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_ NC Driver's License # \_\_\_\_\_

Where Employed \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

How did you hear about Country Day Montessori School?

Advertisement \_\_\_\_\_ Friend/Referral \_\_\_\_\_

Does your child currently attend another school? \_\_\_\_\_ If so, reason for changing school:

\_\_\_\_\_

Has your child ever attended a Montessori Program? \_\_\_\_\_

If so, which one? \_\_\_\_\_

Does your child have any developmental delays that you are aware of?

\_\_\_\_\_

Does your child have any known allergies: No \_\_\_ Yes \_\_\_

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

COUNTRY DAY MONTESSORI SCHOOL OF RALEIGH

Location: 708 Gannett Street, Raleigh, NC 27606 ♦ Mailing Address: 702 Gannett Street, Raleigh, NC 27606

Phone: 919.851.4054 ♦ Fax: 919.851.0940 ♦ URL: [www.countrydaymontessorischool.com](http://www.countrydaymontessorischool.com)

Please give any information concerning your child which will be helpful in his/her experience in group setting (such as play, eating and sleeping habits, special fears, special likes or likes or dislikes):

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**Emergency Care Information:**

Name of child's doctor \_\_\_\_\_ Office Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of child's dentist \_\_\_\_\_ Office Phone \_\_\_\_\_

Address \_\_\_\_\_

Hospital preference \_\_\_\_\_ Phone \_\_\_\_\_

Emergency contact/drop off/pick up authorization:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

\_\_\_\_\_  
*Signature of Parent* *Date*

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event to emergency. In an emergency situation other children in the facility will be supervised by a responsible adult. CDM staff will not administer any drug or any medication, except in cases of emergency. Provisions will be made for adequate and appropriate rest and outdoor play.

\_\_\_\_\_  
*Signature of Operator* *Date*