APPLICATION FOR ENROLLMENT

Enrollment date requested _____ Today's Date _____

CHILD INFORMATION:

Name of Child _____
Last *First* *Middle* *Nickname*

Birthdate _____ Male _____ Female _____ Age _____

Physical Address _____

Child lives with: _____

FAMILY INFORMATION:

Father/Guardian's Name _____ Home Phone _____

Address _____ Zip Code _____
If different from child's

Email _____ Cell Phone _____

Where Employed _____ Work Phone _____

Mother/Guardian's Name _____ Home Phone _____

Address _____ Zip Code _____
If different from child's

Email _____ Cell Phone _____

Where Employed _____ Work Phone _____

How did you hear about Country Day Montessori School?

Advertisement _____ Friend/Referral _____ Other _____

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? _____

If so, please elaborate? _____

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional.
Is there a medical action plan attached? Yes☐ No☐

List any allergies and the symptoms and type of response required for allergic reactions.

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns

List any particular fears or unique behavior characteristics the child

List any types of medication taken for health care needs

Share any other information that has a direct bearing on assuring safe medical treatment for your child

EMERGENCY CARE INFORMATION:

Name of child's doctor_____ Office Phone_____

Address_____

Hospital preference_____ Phone_____

EMEREGENCY CONTACT/ DROP OFF/PICK UP AUTHORIZATION *(other than self):*
Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals

Name	*Relationship*	*Phone Number*
Name	*Relationship*	*Phone Number*
Name	*Relationship*	*Phone Number*

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian *Date*

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Operator *Date*