Application for Admission

Please return form with a non-refundable $150.00 Registration Fee and $95.00 Supply Fee

Once Application is Submitted Parents will be contacted for an Interview with the Head of School.

Child's Name _____Birth date_____

Enrollment (start date) _____Gender M ____ F____

Please circle which program you are interested in:

5 Full Days (6:30 AM to 6:30 PM) **3 Full Days (6:30 AM to 6:30 PM)**

5 Half Days (8:00 AM to 12:00 PM)

5 School Days (8:00 AM to 3:00 PM) **3 School Days (8:00 AM to 3:00 PM)**

FAMILY INFORMATION

Parent 1 / Guardian's Name_____

Home Address: Street_____

City_____State_____Zip_____

Home Phone#_____Cell#_____Work#_____

***Place a check next to the best number to reach you during childcare hours.**

Occupation and Place of Employment_____

Email Address:_____

Parent 2 /Guardian's Name_____

Home Address(if different): Street_____

City_____State_____Zip_____

Cell#_____Work#_____

Parent 2's Email Address: _____

Parent #2's Occupation and Place of Employment_____

Does your child have any medical or special education needs that we should be aware of?

If yes, please list: _____

Does your child take any medications? Please list: _____

Does your child have any allergies? **Please provide doctor's diagnosis and treatment** and list here.

_____

_____

Have there been any changes in your family or home life recently that have affected

your child? _____

Name of Previous School Attended:

Name and Contact Information for Previous Teacher:

Please provide any additional information about your child that may assist us:

_____

_____

_____

_____

_____

Please note: We must have a current immunization record and a doctor's health evaluation signed by your child's physician on file before enrollment day. No child will start school without this completed, signed form on file.

ADDITIONAL PERSONS AUTHORIZED TO DROP OFF OR PICK UP YOUR CHILD

1. Name_____Relationship _____

   Home Phone_____ Cell _____

   Driver's License _____

2. Name_____Relationship _____

   Home Phone_____ Cell _____

   Driver's License _____

EMERGENCY CARE INFORMATION

Child's Doctor: _____Office Phone _____

Hospital Preference: _____ Phone _____

Medical Insurance Provider_____

Policy#_____

In the event of the need for emergency medical care and the parent, guardian or family physician cannot be immediately contacted; I authorize the staff of Montessori Kids Universe to seek the medical facility or physician of their choice to provide emergency care.

Signature: _____ Date:_____

EMERGENCY CONTACTS: *Must have full addresses and phone numbers.*

(People who can be called in the event we cannot reach you)

1. Name_____

   Home Phone_____ Cell_____

   Address: _____ City_____ State_____ Zip_____

2. Name_____

   Home Phone_____ Cell_____

   Address: _____ City_____ State_____ Zip_____

Signature: _____ **Signature:** _____