



MONTESSORI KIDS UNIVERSE™

Application for Admission

Please return form with a non-refundable \$120.00 Registration Fee and \$85.00 Supply Fee

Child's Name _____ Birth date _____

Enrollment (start date) _____ Gender M ____ F ____

5 full days ____ 5 half days ____ 3 full days ____ 3 half days ____

before care ____ after care ____

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.

[Type text]

[Type text]

[Type text]

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

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 _____

Signed _____ Date _____

Signed _____ Date _____