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.

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____

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:

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MONTESSORI KIDS UNIVERSE™

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:** ______________________________

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