ORIGINS MONTESSORI SCHOOL

Date Application Completed_____ Date of Enrollment_____

CHILD'S APPLICATION FOR ENROLLMENT

CHILD INFORMATION:

Date of Birth: _____

Full Name: _____
Last First Middle Nickname

Child's Physical Address: _____

FAMILY INFORMATION:

Child lives with: _____

Father/Guardian's Name _____ Home Phone _____

Address (if different from child's) _____Zip Code _____

Work Phone_____ Cell Phone_____

Mother/Guardian's Name _____Home Phone_____

Address (if different from child's) _____ Zip Code _____

Work Phone_____ Cell Phone_____

Email_____

CONTACTS: 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	Address	Phone Number
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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 child's parent or health care professional must complete the medical action plan.
Is there a medical action plan attached? Yes__ No__

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

_____

EMERGENCY MEDICAL CARE INFORMATION:

Name of health care professional _____Office Phone _____

Hospital preference _____Phone _____

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, a responsible adult will supervise other children in the facility. 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 Administrator_____ Date_____