

HERITAGE MONTESSORI INC.

1289 Marlborough Court, Unit 20
Oakville, Ontario, L6H 2R9
Tel: 905-842-3061

APPLICATION FOR ADMISSION
TODDLER & CASA

Please print the required information.

(Please Circle) **Full Day / Half Day (A. M. / P. M.)**

(Please Circle) **Days: Monday / Tuesday / Wednesday / Thursday / Friday**

Application for:

- Full Day Program 7:00 a.m. to 6:00 p.m. _____
- Half Day Morning Program 9:00 a.m. to 11:30 a.m. _____
- Half Day Morning Program plus Lunch 9:00 a.m. to 12:30 p.m. _____
- Half Day Afternoon Program 1:00 p.m. to 3:30 p.m. _____
- Before School Program 7:00 a.m. to 9:00 a.m. _____
- After School Program 3:30 p.m. to 6:00 p.m. _____

Start Date: _____ **Withdrawal Date:** _____

Name of Child:

Family Name: _____ **Given Name:** _____

Full Address:

Street: _____ **Apt. / Unit #:** _____

City: _____ **Province:** _____ **Postal Code:** _____

E-Mail Address: _____

Birth Date: Month: _____ Day: _____ Year: _____ (**Age:** _____) **Sex:** _____

INFORMATION ABOUT PARENTS / GUARDIANS:

Parent # 1: _____ **Occupation:** _____

Home Address: _____ **Postal Code:** _____ **Phone No.:** _____

Work Address: _____ **Cell No.:** _____

_____ **Postal Code:** _____ **Phone No.:** _____

Parent # 2: _____ **Occupation:** _____

Home Address: _____ **Postal Code:** _____ **Phone No.:** _____

Work Address: _____ **Cell No.:** _____

_____ **Postal Code:** _____ **Phone No.:** _____

IN CASE OF AN EMERGENCY, IF PARENTS CANNOT BE CONTACTED:

Name: _____ **Relationship:** _____

Home Phone No.: _____ **Cell No.:** _____ **Work Phone No.:** _____

Name of authorized person to receive your child at the end of school:

Signature of Parent / Guardian

Date: MM / DD / YYYY

MEDICAL INFORMATION

To be completed by all applicants

Surname of Child: _____ **First Name of Child:** _____

M / F: _____ Date of Birth (MM / DD / YY): _____

Name of Physician: _____

Address: _____ City: _____

Postal Code: _____ Telephone: (_____) _____

Does your child have allergies? Yes / No _____ If yes, please describe: _____

Food: _____ Reaction: _____

Drugs: _____ Reaction: _____

Environment: _____ Reaction: _____

Treatment: _____

Prevention: _____

Has your child had any **communicable diseases** such as chicken pox, mumps, etc.?

If yes, please describe and give dates: _____

Does your child take any medication regularly? Yes / No _____ If yes, name of drug,

reason and dosage: _____

Has your child ever had his/her eyes tested? Yes / No _____ Result: _____

Has your child ever had his/her hearing tested? Yes / No _____ Result: _____

If your child is not able to participate in certain school activities, please specify:

Please comment on your child's overall health: _____

Does your child have any special instructions regarding rest: _____

Dietary Restrictions:

List any foods your child should not eat for medical, dietary, or religious reasons:

(An alternate lunch or snack will be provided for any allergies or food restrictions.)

Immunization:

Please provide TWO photocopies of your child's current personal immunization record.

Relative or person to be notified if parents cannot be reached:

1. Emergency Contact: _____
Telephone: _____ Relationship: _____
Cell No.: _____

2. Emergency Contact: _____
Telephone: _____ Relationship: _____
Cell No.: _____

3. Emergency Contact: _____
Telephone: _____ Relationship: _____
Cell No.: _____

Additional Information:

Home Language: _____ Does your child speak English? Yes/No _____

Names and ages of brothers and sisters: _____

How did you learn about Heritage Montessori Inc.?

Newspaper _____ Flyer _____ Friend _____ Sign _____ Web-site _____

Other _____

ILLNESS POLICY

It is in the highest interest of your child and the other children at Heritage Montessori Inc., to keep your child at home when he/she is ill.

*After a fever, your child's temperature must be normal (37 Celsius) for 24 hours before returning to school.

*Any child with discharging eyes may not return to school until eyes have been free of discharge for 24 hours.

*Any child with diarrhea may not return to school until he/she has a normal stool within a 24 hour period.

*Any child that has vomited may not attend school until he/she has not vomited for a 24 hour period.

If your child becomes ill at school and you are notified, you are requested to please pick-up your child promptly. You will not be called unless your child needs to be at home.

Signature of Parent / Guardian

Date: MM / DD/ YYYY

Signature of Administrator

Date: MM / DD/ YYYY

EMERGENCY CONSENT FORM

In case of an emergency resulting from an accident or illness, if prompt medical attention is deemed necessary and the parents cannot be contacted immediately, permission is hereby given to take the below mentioned child to the nearest medical facility and to proceed with medical treatment. I understand that any medical expenses incurred for such treatment are my responsibility.

Name of the Child _____
(Please print)

Signature of Parent / Guardian _____ Date _____

CHILD RELEASE AUTHORIZATION FOR:

(Please print your child's full name)

Dear Parents / Guardians,

In order to protect your child, we require an authorization by the parent / guardian when individuals other than the parents / guardians pick-up your child. Please list below **ALL** individuals who will come to pick-up your child. For security reasons, photo identification will be required upon pick-up.

This form will be kept on file, and additional names may be added at a later date.

**YOUR CHILD WILL NOT BE RELEASED TO ANY PERSON
NOT LISTED BELOW:**

1. Name: _____
Address: _____
Phone No.: _____ Relationship: _____

2. Name: _____
Address: _____
Phone No.: _____ Relationship: _____

3. Name: _____
Address: _____
Phone No.: _____ Relationship: _____

4. Name: _____
Address: _____
Phone No.: _____ Relationship: _____

5. Name: _____
Address: _____
Phone No.: _____ Relationship: _____