**Office Use Only:**
Application Fee ($_____)
Date:_______________
Chq#:______
Requested Start Date:
__________________

# PARKDALE MONTESSORI SCHOOL
# APPLICATION FORM - ELEMENTARY PROGRAM

## CHILD'S INFORMATION:

**Child's Name:** ________________________ ________________________________________
Last Middle First

**Date of Birth**: ___________________ (DD/MM/YY) **Gender:** Male ____ Female ____

## CONTACT INFORMATION:

| | Mother/Guardian | Father/Guardian |
|---|---|---|
| **Name** (First and Last) | | |
| **Complete Home Address** | | |
| **Complete Workplace Address** | | |
| **Home Phone** | | |
| **Work Phone** | | |
| **Mobile** | | |
| **E-mail** | | |

## EMERGENCY CONTACT INFORMATION: (*One contact minimum is required; other than parents*)

| | Person #1 | Person #2 |
|---|---|---|
| **Name** (First and Last) | | |
| **Relationship to Child** | | |
| **Phone number** | | |
| **Authorized to pick-up my child for reasons other than emergency** | ☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No** |

## AUTHORIZED PICK-UP: *(Other than parents or emergency contact)*

**We, the undersigned, understand that by adding a name on this list, Parkdale Montessori School will release our child to the named authorized pick-up person, without calling us first. The School administration team recommends that when you send someone other than a parent to pick up your child, you notify the School staff at least verbally, but preferably via email.**

| | Person #1 | Person #2 |
|---|---|---|
| **Name** (First and Last) | | |
| **Relationship to Child** | | |
| **Phone number** | | |

## CHILD SPECIFICS:

| | | |
|---|---|---|
| **Physician** | Full name | ------------------------------------------------------------------------------------ |
| | Phone # | ------------------------------------------------------------------------------------ |
| | Full Address | ------------------------------------------------------------------------------------ |

**Allergies**
(please describe) ------------------------------------------------------------------------------------

☐ Allergy has been verified by a doctor ☐ Allergy is life-threatening ☐ Child has an epipen ☐ Child has medication other than epipen

**Dietary restriction**
(please list) ------------------------------------------------------------------------------------

☐ Due to a known intolerance ☐ Due to suspected allergy not listed above ☐ Due to suspected intolerance ☐ Due to religious or other believes

**Medical condition**
(please specify) ------------------------------------------------------------------------------------

☐ Requires medication ☐ Requires cream or ointment ☐ Requires specific care

Please note that a separate form must be filled in for any medication including epipen.

**Health Card Number**
(optional) ------------------------------------------------------------------------------------

**ATTENDANCE OPTION:** (Please indicate)

☐ Full-time (8:20 am to 3:45 pm) ☐ Precare (7:30 am to 8:20 am) ☐ Aftercare (3:45 pm to 5:30 pm)

**PAYMENT PLAN:** (Please indicate)

☐ Option A: lump sum payment ☐ Option B: payments over 7 months

**SIGNATURES:**

Signature of Mother/Guardian: ________________________________ Date: _____________________

Signature of Father/Guardian: ________________________________ Date: _____________________

* Application form must be accompanied by a non-refundable and non-transferable $150 fee.
* Lower Elementary (i.e. grade 1, 2 and 3): Children must have completed the requirements of a Montessori Casa program OR come for a visit in our Elementary classroom prior to acceptance.
* Upper Elementary (equivalent of grade 4, 5 and 6): Children must have completed the requirements of a Montessori Lower Elementary program.
* Previous school records must be submitted prior to acceptance in Lower or Upper Elementary.