

CHILD SPECIFICS:

Physician	Full name	-----	
	Phone #	-----	
	Full Address	-----	
Allergies (please describe)	-----		
<input type="checkbox"/> Allergy has been verified by a doctor	<input type="checkbox"/> Allergy is life-threatening	<input type="checkbox"/> Child has an epipen	<input type="checkbox"/> Child has medication other than epipen
Dietary restriction (please list)	-----		
<input type="checkbox"/> Due to a known intolerance	<input type="checkbox"/> Due to suspected allergy not listed above	<input type="checkbox"/> Due to suspected intolerance	<input type="checkbox"/> Due to religious or other beliefs
Medical condition (please specify)	-----		
<input type="checkbox"/> Requires medication	<input type="checkbox"/> Requires cream or ointment	<input type="checkbox"/> 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 pm) Aftercare (3:45pm 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 must be accompanied by a non-refundable and non-transferable \$150 fee.
- * Children must have completed the requirements of a Montessori Casa program or come for several visits in the Elementary classroom prior to acceptance.
- * Previous school records must be submitted prior to acceptance.