



# **PARKDALE MONTESSORI SCHOOL** **APPLICATION FORM - CASA PROGRAM**

<b>Office Use Only:</b> Application Fee (\$____) Date:_____ Chq#:_____ Requested Start Date:_____ _____
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## **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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:**

<b>Physician</b>	Full name	-----		
	Phone #	-----		
	Full Address	-----		
<b>Allergies</b> (please describe) -----				
<input type="checkbox"/>	Allergy has been verified by a doctor	<input type="checkbox"/>	Allergy is life-threatening	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Child has an epipen	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Child has medication other than epipen	
<b>Dietary restriction</b> (please list) -----				
<input type="checkbox"/>	Due to a known intolerance	<input type="checkbox"/>	Due to suspected allergy not listed above	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Due to suspected intolerance	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Due to religious or other beliefs	
<b>Medical condition</b> (please specify) -----				
<input type="checkbox"/>	Requires medication	<input type="checkbox"/>	Requires cream or ointment	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Requires specific care	
Please note that a separate form must be filled in for any medication including epipen.				
<b>Health Card Number</b> (optional) -----				

**ATTENDANCE OPTION:** (Please indicate)

- ☐ Full-time (8:30 am to 3:30 pm)      ☐ Half-day (8:30 am to 11:30 am)
- ☐ Hot lunch (fees apply)      ☐ Precare (7:30 am to 8:30 am)      ☐ Aftercare (3:30 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 must be accompanied by a non-refundable and non-transferable \$150 fee.

\* Children must be toilet-trained prior to enrolling.