# The Bilingual Montessori School of Sharon

## REGISTRATION

TUITION

**Toddler** 15 months – 3 years

| | | |
|---|---|---|
| 5 days | 8:00 am - 4:00 pm | **$985**/session |
| 3 days | 8:00 am - 4:00 pm | **$804**/session |

**Primary** 3 – 6 years

| | | |
|---|---|---|
| 5 days | 8:00 am - 4:00 pm | **$927**/session |
| 3 days | 8:00 am - 4:00 pm | **$766**/session |

Extended hours $19 per hour

- Registration and Materials Fee $250 per students
- Tuition to be paid in full upon registration
- Minimum 2 Sessions Enrollment

**Registration Due April 15, 2018**

Child's Name _____

Date of Birth _____

PROGRAM ☐ Toddler ☐ Primary

**SESSION 1** (June 11 – 22) Days _____ Hours _____
Athletic Program

**SESSION 2** (June 25 – July 6, Closed July 4) Days _____ Hours _____
Water Program

**SESSION 3** (July 9 – July 20) Days _____ Hours _____
Arts, Crafts and Music Program

**SESSION 4** (July 23 – August 3) Days _____ Hours _____
Drama Program

**SESSION 5** (August 6 – August 17) Days _____ Hours _____
Science and Exploration Program

**Total Cost** $_____

☐ I understand that fees are not refundable and do not apply to other sessions.

Parent/Guardian Signature _____

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# APPLICATION

☐ Toddler ☐ Primary

Full Name _____
First Middle Last Preferred Name

Address _____
Street City State Zip

Phone _____ Date of Birth _____ Gender _____

Current School _____ Current Grade _____ School Phone _____

| PARENTS | Parent 1<br>Mr./Mrs./Ms./Dr. (circle one) | Parent 2<br>Mr./Mrs./Ms./Dr. (circle one) |
|---|---|---|
| Name | | |
| Preferred Name | | |
| Address | | |
| | | |
| Phone | | |
| Cell | | |
| Email Address | | |

## SIBLINGS

Sibling's Name _____ Date of Birth _____ Current School _____

Sibling's Name _____ Date of Birth _____ Current School _____

## RELATIVES

Please provide the names of any The Bilingual Montessori School of Sharon students and/or alumni to whom the applicant is related.

Name _____ Relationship _____

Name _____ Relationship _____

Please feel free to include any information about your family that you think is important for us to know:

_____

How did you hear about The Bilingual Montessori School of Sharon?

☐ Web ☐ Newspaper ☐ Friend (Name) _____

Signature of Parent or Guardian _____ Date _____

The Bilingual Montessori School of Sharon

# FIRST AID AND EMERGENCY MEDICAL CARE CONSENT

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

**Emergency Contacts (*In order to be contacted*)**
Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No___

Health Insurance Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone_____ Cell_____

Parent/Guardian Name: _____ Phone_____ Cell_____

PARENT /GUARDIAN SIGNATURE_____ DATE_____

The Bilingual Montessori School of Sharon

# MEDICATION CONSENT

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)_____**

My child has previously taken this medication_____

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

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Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

**Child's Health Care Practitioner Signature _____Date_____**

**I, _____, (parent or guardian) gives permission**
**(print name)**

**to authorize educator(s) to administer medication to my child as indicated above.**

PARENT /GUARDIAN SIGNATURE_____ DATE_____

For topical, non-prescription not applied to open wound/broken skin (parent signature only)

The Bilingual Montessori School of Sharon

# TRANSPORTATION PLAN AND AUTHORIZATION

CHILD'S NAME:_____

**MY CHILD WILL ARRIVE AT THE PROGRAM**:

___PARENT DROP OFF

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

**MY CHILD WILL DEPART FROM THE PROGRAM**:

___PARENT PICK UP

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

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CHILD'S NAME:_____

**MY CHILD WILL ARRIVE AT THE PROGRAM**:

___PARENT DROP OFF

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

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___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

PARENT /GUARDIAN SIGNATURE_____ DATE_____

**REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION**

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# DEVELOPMENTAL HISTORY AND BACKGROUND

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

**CHILD'S NAME: _____ DATE OF BIRTH: _____**

Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

## DEVELOPMENTAL HISTORY

Age began sitting: _____ crawling: _____ walking: _____ talking: _____

*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____ *Any history of colic? _____

*Does your child use pacifier or suck thumb? _____ *When? _____

*Does your child have a fussy time? _____ *When? _____

*How do you handle this time? _____

## HEALTH

Any known complications at birth? _____

Serious illnesses and/or hospitalizations:_____

Special physical conditions, disabilities:_____

**Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: _____**

_____

_____

Regular medications: _____

## EATING HABITS

Special characteristics or difficulties: _____

*If infant is on a special formula, describe its preparation in detail: _____

_____

Favorite foods: _____

Foods refused: _____

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## DEVELOPMENTAL HISTORY AND BACKGROUND

* Is your child fed held in lap?_____ High chair?_____

* Does your child eat with spoon?_____ Fork?_____ Hands?_____

**TOILET HABITS**

*Are disposable or cloth diapers used? _____*Is there a frequent occurrence of diaper rash?_____

*Do you use: oil:_____ powder:_____ lotion:_____ other:_____

*Are bowel movements regular?_____ How many per day?_____

*Is there a problem with diarrhea?_____ Constipation? _____

*Has toilet training been attempted?_____

*Please describe any particular procedure to be used for your child at the center: _____

_____

*What is used at home? Pottychair? _____ Special child seat? _____ Regular seat? _____

*How does your child indicate bathroom needs (include special words): _____

Is your child ever reluctant to use the bathroom? _____

Does your child have accidents? _____

## SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____

Does your child become tired or nap during the day (include when and how long)? _____

_____

***Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.***

When does your child go to bed at night? _____ and get up in the morning? _____

Describe any special characteristics or needs (stuffed animal, story, mood on waking etc) _____

_____

The Bilingual Montessori School of Sharon

## DEVELOPMENTAL HISTORY AND BACKGROUND

### SOCIAL RELATIONSHIPS

How would you describe your child? _____

_____

Previous experience with other children/day care:_____

_____

Reaction to strangers:_____ Able to play alone?_____

Favorite toys and activities: _____

Fears (the dark, animals, etc.):_____

How do you comfort your child?_____

What is the method of behavior management/discipline at home? _____

_____

What would you like your child to gain from this childcare experience? _____

_____

### DAILY SCHEDULE

Please describe your child's schedule on a typical day. For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc. _____

_____

_____

_____

Is there anything else we should know about your child? _____

_____

_____

_____ _____

(Parent/Guardian Signature) (Date)

The Bilingual Montessori School of Sharon

## EMERGENCY CONTACTS

Name of Student _____ Date of Birth _____

Allergies _____

**Parent 1**

Name _____

Phone number _____

**Parent 2**

Name _____

Phone number _____

**Emergency contacts if parent cannot be reached.**

**Emergency Contact 1**

Name _____

Phone number _____

**Emergency Contact 2**

Name _____

Phone number _____