The Bilingual Montessori School of Sharon

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 Mr./Mrs./Ms./Dr. (circle one)	Parent 2 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_____

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

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___PARENT DROP OFF

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/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

The Bilingual Montessori School of Sharon

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: _____

The Bilingual Montessori School of Sharon

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) _____

_____

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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)

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REGISTRATION

TUITION

Toddler 15 months – 3 years

5 days	8:00 am - 4:00 pm	**$956**/session
3 days	8:00 am - 4:00 pm	**$781**/session

Primary 3 – 6 years

5 days	8:00 am - 4:00 pm	**$900**/session
3 days	8:00 am - 4:00 pm	**$743**/session

Extended hours $15.50 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, 2017

Child's Name _____

Date of Birth _____

PROGRAM ☐ Toddler ☐ Primary

Session 1 (June 12 – 23) Days _____ Hours _____
Athletic Program

Session 2 (June 26 – July 7, Closed July 4) Days _____ Hours _____
Water Program

Session 3 (July 10 – July 21) Days _____ Hours _____
Arts, Crafts and Music Program

Session 4 (July 24 – August 4) Days _____ Hours _____
Drama Program

Session 5 (August 7 – August 18) 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 _____

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 _____

Emergencey Contact 2

Name _____

Phone number _____