



# Application for Admission

**OFFICE USE ONLY**

In Pro Care \_\_\_\_\_

Paid reg. fee \_\_\_\_\_

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthday \_\_\_\_\_  
*Last First Middle*

Address \_\_\_\_\_  
*Street City State Zip*

Program :  Full Day  Half Day Days to Attend :  Mon.  Tues.  Wed.  Thurs.  Fri.

Anticipated date of entrance \_\_\_\_\_ Previous school attended \_\_\_\_\_

Does your child nap?  Yes  No Does your child use the toilet?  Yes  No

## Identifying Information

Parent or Guardian Name \_\_\_\_\_

SSN \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone Carrier \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

Employer ( or school attending ) \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

## Emergency contacts and persons authorized to take child from facility

*other than a parent or doctor that may act as agent of parent (must have 3) - No other person will be authorized:*

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Other Phone \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Other Phone \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Other Phone \_\_\_\_\_

Address \_\_\_\_\_

*If you want to arrange for another person to pick up your child, please notify the office.*

**Allergies** \_\_\_\_\_

**Reaction** \_\_\_\_\_ **Treatment** \_\_\_\_\_

**Comments on Student's Development** (*note: habits, special language, etc.*)

Has your child been stung by a bee or wasp?  Yes  No If so, please describe the reaction \_\_\_\_\_

### Authorization for Emergency Medical Care

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I hereby authorize Hope Montessori Academy to contact:

Pediatrician \_\_\_\_\_ Group/Office \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Group/Office \_\_\_\_\_ Phone \_\_\_\_\_

*For emergency treatment of my child, my preferred hospital is:*

Hospital \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

### Enrollment Agreements

- (A) At the time of initial enrollment, a non-refundable enrollment fee of \$125.00 is due. I have been informed that a two week written withdrawal notice is required.
- (B) I understand that when I am given a guaranteed date for my child/ren to start at HMA, I have 2 weeks from said date to start my child/ren, or agree to begin paying the weekly tuition to hold the space, or be placed on a new waiting list for a future date subject to availability and determined by HMA.

### Trip Permission

I  do  do not give consent for my child to take part in field trips or excursions with Hope Montessori Academy under proper supervision. It is my understanding that I will be notified prior to a trip.

### Model Release

I  do  do not give consent for photographs of my child to be used in the Hope Montessori Academy web site and/or in print advertising for the school.

### Agreements

- (A) I have been informed that parent/teacher conferences are held at regularly scheduled intervals.
- (B) When my child is ill, it is understood and agreed that he/she may not be accepted into care.
- (C) I have read and accept this facility's policies pertaining to admission, care, and discharge of children.
- (D) I have been informed that a copy of licensing rules for child day care centers in Colorado is available in the office for review.
- (E) I have read and accept this facility's policies pertaining to payment of tuition.
- (F) I will keep Hope Montessori Academy updated on any address, phone, or work number changes.

Date \_\_\_\_\_ Parent or legal guardian signature \_\_\_\_\_

(Up)Date \_\_\_\_\_ Parent or legal guardian signature \_\_\_\_\_

(Up)Date \_\_\_\_\_ Parent or legal guardian signature \_\_\_\_\_