Hope
MONTESSORI ACADEMY

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 Required upon Admission Home Phone _____

Cell Phone _____

Cell Phone Carrier _____

Address _____

Occupation _____

Employer (or school attending) _____

Business Address _____

Business Phone _____

E-mail Address _____

Parent or Guardian Name _____

SSN Required upon Admission 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 _____