



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 _____ Parent or Guardian Name _____

SSN Required upon Admission Home Phone _____ SSN Required upon Admission Home Phone _____

Cell Phone _____ Cell Phone _____

Cell Phone Carrier _____ Cell Phone Carrier _____

Address _____ Address _____

Occupation _____ Occupation _____

Employer (or school attending) _____ Employer (or school attending) _____

Business Address _____ Business Address _____

Business Phone _____ Business Phone _____

E-mail Address _____ 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 \$150.00 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 _____