

Montessori Academy of North Texas Admission Form

Director: Angela Magers

Application Date: _____	Admission Date: _____	Withdraw Date: _____
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PARENT/GUARDIAN INFORMATION:

Parent /Guardian 1	First Name: _____	M.I.: _____	Last Name: _____
Address: _____		City _____	State _____ Zip _____
Occupation: _____	Home Phone: () _____		
Employed By: _____	Mobile Phone: () _____		
Work Address: _____	Work Phone: () _____		
<input type="checkbox"/> Custodial Parent (If married, mark both parents)		Date of Birth: _____	
Email: _____		Driver's License #: _____	
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced* <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____		
	*If divorced, court order on file: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relationship to Child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other _____		
Mark All that Apply:	<input type="checkbox"/> Child Lives With <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Pickup		

Parent /Guardian 2	First Name: _____	M.I.: _____	Last Name: _____
Address: _____		City _____	State _____ Zip _____
Occupation: _____	Home Phone: () _____		
Employed By: _____	Mobile Phone: () _____		
Work Address: _____	Work Phone: () _____		
<input type="checkbox"/> Custodial Parent (If married, mark both parents)		Date of Birth: _____	
Email: _____		Driver's License #: _____	
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____		
Relationship to Child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other _____		
Mark All that Apply:	<input type="checkbox"/> Child Lives With <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Pickup		

STUDENT INFORMATION:

1st Child	First Name: _____	M.I.: _____	Last Name: _____
Name child prefers to be called: _____		Grade/Class: _____	
Child's Address: <input type="checkbox"/> Same as above _____			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____	Child's SS #: _____ - _____ - _____	

List any special problems your child may have, existing medical conditions, medication prescribed for long-term continuous use, previous serious illness, injury or hospitalization during the past 12 months, and/or special attention your child may require?

Does your child have any diagnosed food allergies
 None
 Yes- Plan submitted on:

Please list diagnosed allergies _____

Intolerance:
 None
 Yes Please list _____

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800)514-0301(voice) or (800)514-0383 (TTY).

Signature _____ **Date** _____

STUDENT INFORMATION (CON'T):**2nd Child**

First Name: _____ M.I. _____ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address: Same as above _____Gender: Male Female Date of Birth: _____ Child's SS #: _____ - _____ - _____List any special problems your child may have, existing medical conditions, medication prescribed for long-term continuous use, previous serious illness, injury or hospitalization during the past 12 months, and/or special attention your child may require?

_____Does your child have any diagnosed food allergies None Yes- Plan submitted on:

Please list diagnosed allergies _____

Intolerance: None Yes Please list _____

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800)514-0301(voice) or (800)514-0383 (TTY).

3rd Child

First Name: _____ M.I. _____ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address: Same as above _____Gender: Male Female Date of Birth: _____ Child's SS #: _____ - _____ - _____List any special needs that your child may have, existing medical conditions, medication prescribed for long-term continuous use, previous serious illness, injury or hospitalization during the past 12 months, and/or special attention your child may require?

_____Does your child have any diagnosed food allergies None Yes- Plan submitted on:

Please list diagnosed allergies _____

Intolerance: None Yes Please list _____

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800)514-0301(voice) or (800)514-0383 (TTY).

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician: _____ Address: _____ Phone #: _____

Name of Emergency Medical Care Facility/Hospital: _____ Address: _____ Phone #: _____

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature – Parent or Legal Guardian**PHOTO/VIDEO RELEASE:** I understand images of my child(ren), captured during regular and special Montessori Academy of North Texas activities through video, photo, and digital camera, will be used solely for the purposes of MANT publications, website, and promotional material and waive any rights of compensation or ownership thereto. I understand video surveillance cameras are located throughout MANT, including my child(ren)'s classroom and images are accessible via the MANT website for all parents/guardians with children in the classroom to view via a secured website & DVR login.

Signature – Parent or Legal Guardian**SCHOOL AGE STUDENTS:** My child attends the following school: _____

Address: _____ Phone #: _____

 His/her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

Signature – Parent or Legal Guardian

Signature _____ Date _____

EMERGENCY CONTACTS & AUTHORIZED PICKUP PERSONS:

1st Contact/Pick Up	First Name: _____ M.I.: _____ Last Name: _____
Address: _____ City _____ State _____ Zip _____	
Relationship to Child: _____	
Home Phone: () _____ Cell Phone: () _____	
Occupation/Employer: _____ Work Phone: () _____	
<input type="checkbox"/> Emergency Contact	
<input type="checkbox"/> Authorized to pick up Driver's License # _____	
<input type="checkbox"/> All children in the family <input type="checkbox"/> Only the following child(ren): _____	

2nd Contact/Pick Up	First Name: _____ M.I.: _____ Last Name: _____
Address: _____ City _____ State _____ Zip _____	
Relationship to Child: _____	
Home Phone: () _____ Cell Phone: () _____	
Occupation/Employer: _____ Work Phone: () _____	
<input type="checkbox"/> Emergency Contact	
<input type="checkbox"/> Authorized to pick up Driver's License # _____	
<input type="checkbox"/> All children in the family <input type="checkbox"/> Only the following child(ren): _____	

3rd Contact/Pick Up	First Name: _____ M.I.: _____ Last Name: _____
Address: _____ City _____ State _____ Zip _____	
Relationship to Child: _____	
Home Phone: () _____ Cell Phone: () _____	
Occupation/Employer: _____ Work Phone: () _____	
<input type="checkbox"/> Emergency Contact	
<input type="checkbox"/> Authorized to pick up Driver's License # _____	
<input type="checkbox"/> All children in the family <input type="checkbox"/> Only the following child(ren): _____	

4th Contact/Pick Up	First Name: _____ M.I.: _____ Last Name: _____
Address: _____ City _____ State _____ Zip _____	
Relationship to Child: _____	
Home Phone: () _____ Cell Phone: () _____	
Occupation/Employer: _____ Work Phone: () _____	
<input type="checkbox"/> Emergency Contact	
<input type="checkbox"/> Authorized to pick up Driver's License # _____	
<input type="checkbox"/> All children in the family <input type="checkbox"/> Only the following child(ren): _____	

PARENT INVOLVEMENT/VOLUNTEER: I would like to participate and or volunteer for the following activities:		
<input type="checkbox"/> Read to my child's class	<input type="checkbox"/> Sherman Arts Fest booth	<input type="checkbox"/> Classroom events
<input type="checkbox"/> Field Day	<input type="checkbox"/> Spring Fling	<input type="checkbox"/> Special projects (cut, laminate, etc.)
<input type="checkbox"/> Guest Speaker (topics: _____)	<input type="checkbox"/> Other: _____	

Signature _____ **Date** _____

CHECK ALL THAT APPLY:

Transportation

I hereby give do not give -consent for my child to be transported & supervised by the operation’s employees:
 for emergency care on field trips

Field Trips (Elementary and Middle School Students Only):

I hereby give do not give -consent for my child to participate in Field Trips

Water Activities

I hereby give do not give -consent for my child to participate in Water Activities:
 water table play sprinkler play splashing/wading pools swimming pools

Receipt of Written Operational Policies/Student Handbook:

I acknowledge receipt of the facility’s operational policies, including those for discipline & guidance. The handbook is accessible on the MANT website at www.montessorisherman.com and can be downloaded.

Elementary & Middle School Students: I acknowledge receipt of the facility’s operation policies, including those for discipline & guidance. Student Signature _____

I understand that the following meals will be served to my child while in care: AM Snack PM Snack

My child is normally in care on the following days & times:

Half Day (Monday – Friday) 7:30 a.m. – 11:30 a.m. Extended Day (Monday – Friday) 7:30 a.m. – 3:00 p.m.
 Full Day (Monday – Friday) 7:30 a.m. – 6:00 p.m. Afterschool Program (Mon. – Fri.) 3:15 p.m. – 6:00 p.m.

IMMUNIZATION RECORD & HEARING/VISION SCREEN:

I have provided the childcare operation with a copy of my child(ren)’s most current immunization record.

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement:

My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

OR

I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including a religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Dept. of State Health Services at www.dshs.state.tx.us/immunize/public.shtm

AND

I have provided the childcare operation with a copy of my child(ren)’s birth certificate.

I have provided a current Hearing and Vision screen to the childcare facility. (Required for children age 4 and older by Sept. 1st)

ADMISSION REQUIREMENT:

If your child does not attend pre-k or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation.

HEALTH-CARE PROFESSIONAL’S STATEMENT: I have examined the above named child(ren) within the past year and find that he/she is able to take part in the child care program.

 Health Care Professional’s Signature

 Date

A signed and dated copy of a health care professional’s statement is attached.

Medical diagnosis & treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

Name of Health Care Professional: _____ Address: _____

Signature _____ Date _____

Subscribed and sworn to (or affirmed) before me this _____ day of _____

Signature or notary officer: _____

(seal, if any, or notarial officer)

My Commission Expires: _____