Montessori Schools of Central Texas

Temple Campus

ENROLLMENT APPLICATION FORM (SY 2017-18) August 7, 2017 – May 26, 2018

This information will be held confidential and only be released by signed consent of parent or guardian. Failure to provide complete and accurate medical or behavioral information for your child will be grounds for non-admission or dismissal from The Montessori Schools of Central Texas.

Date of application _____ How did you hear about our school? _____

[ ] New Student [ ] Returning Student [ ] Summer Camp Program Only*

**Open only to previous Montessori students*

Primary Program (3 to 6 year old children)

_____ Full-day Program (6:30 a.m. – 6 p.m.) Before and After School Care provided.
Class begins at 8:30 a.m. and ends at 2:30 p.m.

Student's Name_____ [ ] Male [ ] Female

Address _____ City _____ Zip _____

Home Phone _____ Date of Birth _____ Child's Age _____

Primary Sponsor

Name & Title (Mr./Mrs./Ms./Dr./Other) _____ Work Phone _____

Address _____ City _____ Zip _____
(If different from child)

Email _____ Place of Employment _____

Cell Phone _____ Preferred Phone _____

Secondary Sponsor

Name & Title (Mr./Mrs./Ms./Dr./Other) _____ Work Phone _____

Address _____ City _____ Zip _____
(If different from child)

Email _____ Place of Employment _____

Cell Phone _____ Preferred Phone _____

Child lives with: [ ] both parents [ ] mother [ ] father [ ] step-parent [ ] other _____

Please answer the following medical and behavioral questions:

Has your child ever been dismissed, or withdrawn from a daycare center, private or public school for behavioral problems? [ ] Yes [ ] No If yes, describe the problem and the name of the center or school: _____

_____

Does your child still have this problem? [ ] Yes [ ] No

Does your child hit or have aggressive tendencies toward other children or teachers? [ ] Yes [ ] No

Reason for enrolling your child at the Montessori Schools of Central Texas: _____

_____

Check illnesses your child has had: [ ] Chicken pox [ ] Diphtheria [ ] German Measles [ ] Measles [ ] Mumps [ ] Tonsillitis [ ] Whooping Cough [ ] Asthma [ ] Typhoid [ ] Scarlet Fever [ ] Tuberculosis [ ] Polio [ ] Ear Infections [ ] Allergies* _____
*Listed food allergies require a physician's diagnosis and treatment plan to be submitted with application.

Does your child have vision difficulties? _____ Does your child wear glasses or contacts? _____

Does your child have hearing difficulties? _____ Does your child wear a hearing aid? _____

Does your child have speech difficulties? _____ Does your child attend speech classes? If yes, when and where? _____

Has your child been referred for testing for any learning difficulties? _____

Has your child been diagnosed by a health professional for any learning difficulties? [ ] Yes [ ] No

Is your child presently under the care of a physician, psychologist, or therapist? _____ If so, why?

_____

Does your child take medication on a regular basis? _____ If so, list the medication by name and describe why your child takes it: _____

Does your child wear any special appliances or equipment which will be worn at school including dental appliances? _____

Are there any past or present family situations that could impact your child's attendance, behavior, or stress level?

_____

I certify that the above information is complete and accurate to the best of my knowledge. If there are any changes during the school year, I understand that it is my responsibility to notify the school.

Signature of Parent/Guardian_____ Date _____