Mona Montessori Carrollton, Texas

Application for Admission

Child's Last **Name:**	**First Name:**	
Date of Birth:	Place of Birth(City & State):	
Parent's Names:		
Address:	City:	Zip:
Home Phone:		
Mother's Work Phone:	Father's Work Phone:	
Mobile Phone:	E-Mail:	
With Whom Does the Child Live: Both Parents: ☐ Mother: ☐ Father: ☐ Other: ☐		
If Other, Please Specify Relationship:		
Name:	*Phone:*	
Address:		
Guarantor: (Person Responsible For Registration And Fees):		
Mother's Employer:		
Father's Employer:		

List who else is authorized to pick your child from The Academy – (will have to show their picture ID, so please provide their Driver License number). Include spouse if authorized to pick when the child does not live with both parents.

Name Phone No. & relationship:

Name Phone No. & relationship:

PLEASE PROVIDE IMMUNIZATION RECORDS. IF THE CHILD IS 4 YEARS OR OLDER WE ALSO REQUIRE HEARING AND VISION TEST RESULT REPORTS.

Transportation: I hereby give ☐ do not give ☐ consent for my child to be transported by facility's staff on field trips ☐ to the library or other nearby extra-curricular activities ☐ to and from school ☐

Water Activities: I hereby give ☐ do not give ☐ my consent for my child to participate in water sports provided by the facility: splashing or wading pools ☐ swimming pools ☐

School Age Children: My child attends the following school and his/her immunization records are on file at that school and immunizations and TB test are current.

_____

Please consider my child for admission. I understand there is an annual registration fee. Please read the Fee Schedule, Terms, and Conditions.

I have read and agree to the Fee Schedule & T/C's

Parent (Guardian):Signature _____ ***Date:*** _____***Driver License No.*** _____

For office use only: Class: _____Start Date: _____Drop Date: _____ Fee($)

_____ ___Weekly ____ Monthly

Days in Care: M T W TH F OR (M – F) Hours in Care: Circle one (7 to 6) (7 to 4) (9-4) (9-6)

Comments: _____

Email: info@monamontessori.com or Fax: 972-245-1551

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Emergency Authorization

Child's Last Name:	First Name:
Parents' Names:	

Address:

Guardians Name (If Different From Parents):	
Home Phone Number:	
Mother's Work Number:	Mobile Phone:
Father's Work Number:	Mobile Phone:

If a parent (guardian) cannot be reached in case of emergency, the Academy has permission to contact the following persons in the order listed:

Name:	Phone:
Address	

Name:	Phone:
Address	

Emergency contacts must be reliable persons, who could make themselves available immediately and who have transportation during your child's attendance hours. They must be people whom your child knows well, and who can and are ready to pick your child from school and provide care.

In case the services of a physician are required before either a parent (guardian) or one of the emergency contacts can be reached, the following doctor may give my child any treatment necessary. I (the parent or guardian) assume responsibility for payment of such professional service.

Doctor:	Phone:
Address:	

Is Your Child Allergic To Any Medication:	Pls. Specify:
Is Your Child Allergic To Any Other Substance:	

In case of an emergency, when a parent, guardian, emergency contact, or the above physician cannot be reached, the Academy has my permission to take my child by car, van or ambulance to a hospital. The hospital personnel have my permission to treat the child.

_____ Signature of Parent (or Guardian)

_____ Date

Immunization Record

Name of Child: | **Date of Birth**:

Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
DTP											
Haemophilus influenzae type b											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required) ☐ Positive ☐ Negative Date:

Signature or stamp of a physician or public health personnel verifying immunization information above.

_____ Signature _____ Date

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 _____ and does not need varicella vaccine.

_____ _____

Parent's signature Date

☐ ☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

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

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten 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 or within one week of admission.
Please check only one option:

☐ **HEALTH-CARE PROFESSIONAL'S STATEMENT**: I have examined the above named child within the past year and find that he / she is to take part in the day care program.
☐ A signed and dated copy of a health care professional's statement is at attached
☐ Medical diagnosis and 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.
☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission; I will obtain a health care professional's signed statement and will submit it to the child-care operation.

VISION: R 20/_____ L 20/_____ O PASS O FAIL

HEARING: **1000HZ** : R _____ L _____ **2000HZ:** R_____ L_____ **4000HZ:**: R_____ L: _____
☐ **PASSS** ☐ **FAIL**

Name and Address of health care professional:

Signature: _____ Date: _____