Stepping Stones Montessori School

APPLICATION FOR ADMISSION

I, ____ HEREBY MAKE APPLICATION FOR THE ADMISSION OF

__________________________ AS A STUDENT IN THE STEPPING STONES MONTESSORI SCHOOL FOR THE ACADEMIC TERM BEGINNING SEPTEMBER __________ AND ENDING JUNE ____________.

CHILD'S NAME (LAST) (FIRST) DATE OF BIRTH SEX

ADDRESS (STREET, TOWN, ZIP CODE) HOME PHONE

FATHER (OR GUARDIAN) ____

OCCUPATION ____

EMPLOYER ____

ADDRESS ____

HOME PHONE ____________________________ CELL PHONE ____________________________

BUSINESS PHONE _________________________ EMAIL ADDRESS ____________________________

MARITAL STATUS: _____ MARRIED _____ DIVORCED ______ OTHER

MOTHER (OR GUARDIAN) ____

OCCUPATION ____

EMPLOYER ____

ADDRESS ____

HOME PHONE ____________________________ CELL PHONE ____________________________

BUSINESS PHONE _________________________ EMAIL ADDRESS ____________________________

NAME AND AGES OF SIBLINGS ____

SCHOOLS PREVIOUSLY ATTENDED ____

PLEASE CHECK DESIRED PROGRAMS:

PRIMARY AGES 2 1/2 - 6 THREE DAY PROGRAM AM ____ M T W TH F (PLEASE CIRCLE))

FULL DAY PROGRAM ____ KINDERGARTEN FD _____

LUNCH PROGRAM _____ BEFORE SCHOOL ______ AFTER SCHOOL _____

IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICATION? _____ YES _____ NO

IF SO, PLEASE LIST:

____

WHY DO WISH YOUR CHILD TO ATTEND A MONTESSORI SCHOOL?

____

____

FROM WHAT SOURCE DID YOU FIRST LEARN OF THIS SCHOOL? ______________________________

FOR HOW MANY YEARS DO YOU WISH YOUR CHILD TO ATTEND? ______________________________

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE FULL YEAR TUITION WHETHER OR NOT MY CHILD IS OUT OF SCHOOL BECAUSE OF ILLNESS OR FOR PERSONAL REASONS.

WHEN UNABLE TO REACH ME IN ILLNESS OR EMERGENCY, I AUTHORIZE THE SCHOOL TO RELEASE MY CHILD TO:

____

NAME TELEPHONE

____

NAME TELEPHONE

____

NAME TELEPHONE

I GIVE PERMISSION TO THE SCHOOL TO CONTACT MY CHILD'S DOCTOR OR DENTIST IN ANY EMERGENCY.

____

____

PHYSICIAN

____

ADDRESS TELEPHONE

____

DENTIST

____

ADDRESS TELEPHONE

I GIVE MY CONSENT TO THE PERSON IN AUTHORITY TO SEEK THE NEAREST MEDICAL CARE IN EXTREME EMERGENCY.

_____________________ ____

DATE SIGNATURE OF PARENT OR GUARDIAN