

The Miami Montessori School

An American Montessori Society Affiliate



86 Troy Town Drive Troy, Ohio 45373

(937) 339-0025

NEW STUDENT APPLICATION

Administration Use Only

Date Received _____

Check Number _____

Admission Date _____

Child's Name _____ Child's SSN _____

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

Child's Address _____

Street, City, State Zip

-----The following questions pertain to the Child's Mother-----

Mother's Name _____ Home Phone _____

Home Address _____

Street, City, State Zip

Email _____ Cell _____

Employer _____ Work # _____

Work Address _____

Street, City, State Zip

====The following questions pertain to the Child's Father=====

Father's Name _____ Home Phone _____

Home Address _____

Street, City, State Zip

Email _____ Cell _____

Employer _____ Work # _____

Work Address _____

Street, City, State Zip

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Emergency contacts (besides parents) We need two (2) contact people.

	<u>First Emergency Contact</u>	<u>Second Emergency Contact</u>
Name		
Phone		
Address		
Relationship to child		

Child's Name _____

Physician _____ Physician Phone _____

Physician Address _____
Street, City, State Zip

Dentist _____ Dentist Phone _____

Dentist Address _____
Street, City, State Zip

=====

Either Part I or Part II must be completed. Do not complete both.

Part I. Permission to Transport Child

I give The Miami Montessori School my permission to transport my child

(Name of child)
to _____
(hospital/clinic)
for emergency medical care or to _____
(dentist/clinic)
for emergency dental care, or to the nearest available source of assistance.
Parent's Signature _____
Date _____

- OR -

Part II. Refusal to Grant Permission

I do not give permission to The Miami Montessori School to transport my child,
_____ for emergency
(name of child)
medical or dental care. In the event of an illness, or injury, which requires
emergency medical or dental treatment, I wish The Miami Montessori School to take
the following actions:

Parent's Signature _____
Date _____

Child's Name _____

HEALTH RECORD

1) List all allergies and any special precautions and treatment indicated for these allergies (e.g., foods, medications, or environmental allergies):

2) Is your child a vegetarian? Are there any special food considerations?

3) List medications, food supplements, modified diets, or fluoride supplements currently being administered to the child:

4) List any chronic physical problems and any history of hospitalization:

5) List any diseases the child has had:

6) Has child ever been referred to a psychiatrist or psychologist? _____ If yes, please explain:

7) Does the child have any impairments of:

Hearing _____ Speech _____ Vision _____

PLEASE ATTACH YOUR CHILD'S IMMUNIZATION RECORD

Child's Name _____

DEVELOPMENTAL HISTORY

Fill in the following with age at onset:

Sat alone _____ Smiled _____ Laughed _____

Crawled (on stomach) _____ Babbled _____

Crept (hands and knees) _____ 3-word sentence _____

Walked alone _____ "Mama" and "Dada" with meaning _____

Toilet trained: Day _____ Night _____

Fed self with spoon _____ Handedness: Right _____ Left _____

Type of birth: Normal _____ Abnormal _____
(please explain below)

=====

PERSONAL ADJUSTMENTS

Check any of the following which are of concern to you:

Sleep habits _____ Shy _____ Difficult to discipline _____

Restless _____ Jealous _____ Does not see well _____

Fearful _____ Bites nails _____ Does not hear well _____

Wets bed _____ Sucks thumb _____ Prefers to be alone _____

Destructive _____ Breath holding _____ General slowness _____

Aggressive _____ Talks to self _____ Temper tantrums _____

Lack of affection toward parents _____ Difficulty with bowel movements _____

Speech difficult to understand _____ Does not understand speech _____

Please complete:

1) Physical disabilities: _____

2) Who cares for the child when parents are not home?

How frequently? _____

Siblings: Names/Ages: _____

Present Marriage?: _____ Former Marriage?: _____

Child's Name _____

EDUCATIONAL HISTORY

1) Has your child attended a nursery school? _____

Name: _____

Address: _____

Dates of attendance: _____ to _____

2) Has your child attended an elementary school? _____

Name: _____

Address: _____

Dates of attendance: _____ to _____

1) What are your reasons for enrolling your child in a Montessori School?

2) If accepted, how many years will your child attend our school? _____
(The Miami Montessori School requests a minimum commitment of two years.)

3) I am interested in the following enrollment for my child:

Preschool (3 to 6 year olds):

_____ AM Session (8:30-11:30)

_____ Full Day Session (8:30-3:00)

Lower Elementary Class (6 to 9 year olds):

_____ Full Day Session Only (8:30-3:00)

Upper Elementary Class (9 to 12 year olds):

_____ Full Day Session Only (8:30-3:00)

Parent's Signature

Child's Name _____

Ohio State Law governing licensure for childcare centers requires that we obtain written permission to include you in our school directory. Please complete the following information:

I **AGREE** to have my name, address and phone number printed in The Miami Montessori School Parent Directory

Mother's Name _____

Mother's Address _____
Street, City, State Zip

Mother's Phone _____

Signature _____

Date _____

Father's Name _____

Father's Address _____
Street, City, State Zip

Father's Phone _____

Signature _____

Date _____

-OR-

Please **DO NOT** include my name, address and phone number in The Miami Montessori School Parent Directory (roster).

Signature _____

Date _____

Please return this application to:

The Miami Montessori School
86 Troy Town Drive
Troy, Ohio 45373

Please include a \$125.00 application fee, payable to THE MIAMI MONTESSORI SCHOOL. (Non-refundable)