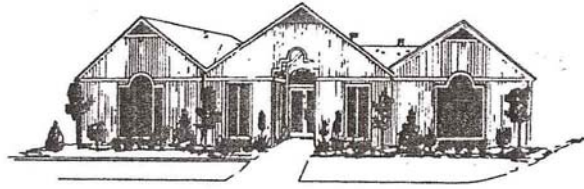


The Miami Montessori School

An American Montessori Society Affiliate



86 Troy Town Drive Troy, Ohio 45373

(937) 339-0025

REENROLLMENT APPLICATION

Administration Use Only
Date Received _____
Check Number _____
Admission Date _____

Child's Name _____

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

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

	First Emergency Contact	Second Emergency Contact
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,

(name of child)
for emergency 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 _____

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

Signature _____

Date _____

Please return this application to:

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