Stepping Stones Montessori School

APPLICATION FOR TODDLER/PRIMARY PROGRAM 2016-2017

I, _____ HEREBY MAKE APPLICATION FOR THE ADMISSION OF _____ AS A STUDENT IN THE STEPPING STONES MONTESSORI SCHOOL FOR THE ACADEMIC TERM BEGINNING SEPTEMBER 6, 2016 AND ENDING JUNE 16, 2017.

_____

CHILD'S NAME (LAST) (FIRST) DATE OF BIRTH ☐ MALE ☐ FEMALE

FAMILY INFORMATION:

_____

MOTHER/GUARDIAN LAST NAME FIRST NAME

_____

HOME ADDRESS CITY STATE/ZIP TOWNSHIP & COUNTY

_____

HOME PHONE HOME EMAIL MOBILE TELEPHONE

_____

EMPLOYER'S NAME OCCUPATION & TITLE BUSINESS TELEPHONE/EMAIL

_____

FATHER/GUARDIAN LAST NAME FIRST NAME

_____

HOME ADDRESS CITY STATE/ZIP TOWNSHIP & COUNTY

_____

HOME PHONE HOME EMAIL MOBILE TELEPHONE

_____

EMPLOYER'S NAME OCCUPATION & TITLE BUSINESS TELEPHONE/EMAIL

PARENTS OR GUARDIANS ARE: ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED

NAME OF STEPPARENTS (IF APPLICABLE)

_____

WITH WHOM DOES APPLICANT LIVE? ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER

_____

NAME AND AGES OF SIBLINGS

_____

PLEASE CHECK DESIRED PROGRAMS: PRIMARY AGES 18 MONTHS TO 6 YEARS

THREE DAY PROGRAM AM (8:30 to noon) M T W TH F (PLEASE CIRCLE)

THREE FULL DAY PROGRAM (8:30 to 3:00 pm) M T W TH F (PLEASE CIRCLE)

FIVE DAY PROGRAM AM (8:30 to noon) _____ FULL DAY PROGRAM (8:30 TO 3:00) _____

KINDERGARTEN FULL DAY PROGRAM (8:30 to 3:00) _____

LUNCH PROGRAM (noon to 1:00) _____ AM CARE (7:00 TO 8:30) _____ AFTER CARE (3:00 TO 6:00) _____

FIVE FULL DAYS WITH MORNING CARE AND AFTER CARE (7:00 AM TO 6:00 PM) _____

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

IF SO, PLEASE LIST:

_____

SCHOOLS PREVIOUSLY ATTENDED:

_____

WHY DO WISH YOUR CHILD TO ATTEND A MONTESSORI SCHOOL?

_____

HOW DID YOU HEAR ABOUT STEPPINGS STONES? ☐ NEWSPAPER ☐ WORD OF MOUTH ☐ INTERNET ☐ OTHER

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 TELEPHONE

ADDRESS TELEPHONE

DENTIST TELEPHONE

ADDRESS

A PAYMENT OF $50.00 (NON-REFUNDABLE REGISTRATION) IS DUE UPON SUBMISSION OF THIS APPLICATION.

DATE **SIGNATURE OF PARENT OR GUARDIAN**